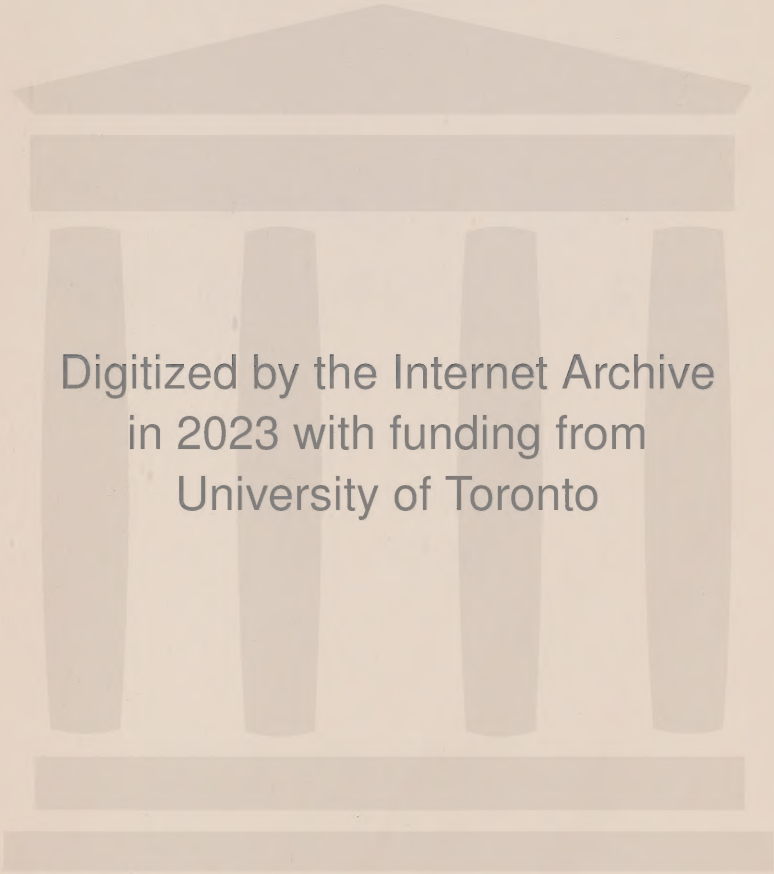
ROYAL COMMISSION ON HEALTH SERVICES

TRENDS IN PSYCHIATRIC CARE

D. G. McKERRACHER

1964



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D.G. McKerracher

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INTRODUCTION

In December 1961, I was asked by Chief Justice Emmett M. Hall, Chairman of the Royal Commission on Health Services, to carry out a research study of trends in psychiatric care. Aware of the need to improve psychiatric services in Canada, the members of the Royal Commission required precise information on the present state of Mental Health Services and on the changes taking place. The Chairman asked Dr. Alex Richman of the University of British Columbia to do a detailed statistical study (including costs) of psychiatric morbidity and facilities in Canada today, and he requested me to prepare a report on the trends and changes in psychiatric care—in Canada and elsewhere. This monograph presents the results of my survey.

To find out how programs for psychiatric care were changing, and to learn about future plans for further change, I visited many psychiatric centers and interviewed those who seemed to be doing the most to develop better services. Not only did I go to all of the Canadian provinces, but also to the United Kingdom and to several centers in the United States. In each center I talked with psychiatrists, non-psychiatric physicians, university teachers, public health administrators, school teachers, social workers, and others interested in psychiatric care.

Here the problem is how to present what I have seen in a report that will be readable, and from which information can be obtained without too much difficulty. Thus, in an attempt to make this statement interesting and clear, each region visited is described separately, but under topic headings common to all.

Among these topics are critical descriptions of each region's psychiatric services—including community programs. These programs not mainly psychiatric, but those with some relation to state-financed psychiatry are also described; these include general hospital and medical services, and voluntary agencies. Special points discussed also include psychiatric services for children, for the old, for alcoholics, as well as trends in legislation and forensic psychiatry.

Since this is a critical review, each program is considered in the light of my personal views of what is good or bad in psychiatry; thus the report is frankly judgemental even though as factual as possible.

Because, in each area reported, it is necessary to interpret the findings in the light of what I have considered progressive or backward, the conclusions at the end of each chapter are somewhat repetitive. It is hoped that any redundancy will at least contribute to clarity.

For obvious reasons, the reports on the psychiatric services in each Canadian province are detailed. Because so many of the radical changes occurring recently in psychiatry have originated in the United Kingdom, the report on the mental health services of Britain are almost equally detailed. Less than justice has been done to the contributions from the United States. This is not due to a failure to recognize what has been accomplished in American psychiatry, but rather to the fact that a report can only contain so much. Moreover, American psychiatry has been well described elsewhere in the recent reports of the Joint Commission on Mental Illness and Health.

To the accounts of psychiatric services in Canada, Britain and the United States, two appendices have been added. These include reports on complementary studies financed through the Royal Commission and carried out by Dr. Colin Smith, Research Psychiatrist in the Department of Psychiatry, University of Saskatchewan, and by Dr. Robin Badgley, formerly Associate Professor of Social and Preventive Medicine of the University of Saskatchewan—but now with the Milbank Foundation in New York.

Finally, I must express appreciation to those who have helped make this work possible. Special thanks should go to Dr. Colin Smith and Dr. Robin Badgley for their advice and criticism, and above all to Professor Bernard Blishen, Director of Research for the Royal Commission. Thanks are also due to my wife for her patient forbearance during almost three years association with the "report" and to my secretary, Mrs. Joan Gerecke, for long hours of accurate typing.

I am grateful to these and to others, not mentioned here, for having been given an opportunity to review such an interesting and challenging topic.

Saskatoon, 1964

D. G. McKERRACHER, M.D.

PART I

CANADA

In January 1962, the Research Director of the Royal Commission on Health Services arranged for a survey of trends in psychiatry today. Since the facts assembled during this study were to be used to improve psychiatric services in Canada, it was necessary to have an up-to-date picture of psychiatry in all ten provinces. I was asked to carry out the survey, in the course of which I made at least one visit to each of the ten provinces. In this section, I shall summarize the information gained during these visits; later in the report, the psychiatric services of each province are described in greater datail.

Since the time that could be spent in any province was short (from a day to a week), the survey deals only with the most pressing problems in each area. I did, however, talk with psychiatrists, general practitioners, university teachers, public health officers, and other key persons, and shall attempt to present an accurate impression of the psychiatric problems and achievements in each province. I have tried to differentiate between facts and impressions, making an effort to verify all items that are presented as fact; on the other hand, the interpretations and opinions expressed are mostly my own, and should be viewed in this light.

CHAPTER 1

A SUMMARY OF TRENDS IN PSYCHIATRY IN CANADA

1. Background to Psychiatry in Canada

Although its roots came from Britain, Canadian psychiatry, as it developed, added grafts from the United States and elsewhere. The institutions built in Ontario during the last half of the 19th Century resembled the British county asylums, which had first appeared in 1810; these Ontario asylums, however, were administered by the Provincial Government—in a pattern more like the American State Hospitals than the British county institutions.

Programs are developed by people, and so a number of unusual leaders have left their imprints on Canadian psychiatry. In the mid-nineteenth Century, during a whirlwind visit to Halifax, Dorothea Dix persuaded the Legislative Assembly to build the Nova Scotia Hospital. In 1878 the Superintendent of that institution relieved his overcrowding by placing chronic mental patients in county homes; thus began Nova Scotia's unique mental health service—with a five hundred bed institution in Halifax for the acutely sick—backed up by a dozen county homes for long-stay patients.

In each of the other nine provinces, outstanding psychiatrists have also left their marks. Dr. R. M. Bucke, the former Superintendent of the asylum at London, Ontario, made sure that Canadian psychiatry maintained close ties with the rest of medicine. Then at the University of Toronto, early in the 20th Century, Dr. C. K. Clarke began teaching psychiatrists and so helped set the stage for Canada's post-graduate training in psychiatry. Just before World War II, the legislation and administration established by Dr. B. T. McGhie set standards in Ontario that still permeate Canadian psychiatry. In other provinces the mentally ill owed much to MacNeill in Saskatchewan, to Barragar in Alberta, to Crease in British Columbia and to many others.

Long before the Federal Government's Mental Health Division did so much to maintain communications between psychiatrists in all provinces, the visits of Dr. Clarence M. Hincks and of other members of the staff of the National Committee for Mental Hygiene kept each province aware of what was going on in other areas.

Regional differences in racial, cultural and topographical characteristics have influenced the form of Provincial psychiatric services. With the greatest population per square mile of any province in Canada, and with this population evenly dispersed throughout, Prince Edward Island, for example, has understandably developed a pattern of service that differs from that in Manitoba; for

Manitoba has half of its population in one city—with the remainder irregularly scattered over 200,000 square miles. With religious organizations and private groups dominating its psychiatry, Quebec, to note another example, presents a different pattern from Saskatchewan, where the Provincial Government has called the tune in psychiatry as it has in so much of the rest of medical care.

In most provinces, regional political currents have affected the facilities for the mentally ill. Many mental hospitals have felt the sting of partisan attack, and have been the subject of political battles. At various times, exposés have shaken hospitals in New Brunswick and Ontario, and, to a lesser extent, in other provinces. In the past, some incoming governments have documented the iniquities of their predecessors by disclosing the limitations of the mental hospitals; too often these new governments, in turn, did little to correct the deficiencies that they had so vigorously denounced.

As Canada has moved towards publicly financed medical programs, "free services" made their appearance in mental hospitals—first in Saskatchewan (1946) and shortly afterwards in Nova Scotia. Except in Quebec where religious orders run the institutions, the administrative responsibility for looking after mentally disordered people has long since rested with a government department —usually Public Health. Many hoped this contact with other health services would improve the public image of psychiatry—and so improve the care of the mentally ill; but this has not necessarily happened. Deputy Ministers of Public Health have not always known what to do with their large mental hospitals. In British Columbia, however, there is a Deputy Minister of Mental Health directly responsible to the Health Minister, and this works well.

Mental hospitals have been in the midst of the universal struggle between those who favour centralization and those who would decentralize. In Nova Scotia, giving administrative responsibility to local boards brought community participation, even though the financing of psychiatric services is mostly from the Provincial Treasury; in most other provinces, mental health services are administered centrally.

The wealth and size of the population of the province often influence its patterns of psychiatric care. Only Ontario, the richest and most populous province, has developed highly specialized institutions. Ontario has separate hospitals for epileptics, for mentally disordered patients with tuberculosis, for the criminally insane, and has recently established research centers for both the study of mental retardation and of emotional problems in children. Occasionally, a province has taken a unique approach to a particular problem; the Province of Alberta has attempted to prevent mental disorder through legislation authorizing, under certain conditions, the sexual sterilization of mentally disordered people; more than 2,000 have been surgically sterilized during the past 35 years.

Yet despite Canada's variations in topography, climate, culture and wealth, there is a surprising uniformity in the administrative approach to most psychiatric problems. Thanks to many chances to share their views, Canadian psychiatrists collaborate more closely than do psychiatrists in most other countries.

2. Psychiatric Services

(a) *For the Mentally Ill*

Traditionally in Canada, psychotics are treated in large institutions, with most mental hospitals containing between 1,000 and 2,000 patients (although

British Columbia has a hospital with nearly 4,000 patients and Quebec one with almost 6,000).

Reacting against large institutions, the Governments of Saskatchewan and Ontario have established small regional hospitals of less than 300 beds, and have developed experimental programs to care for psychotics in general hospitals and in the community. The policy of treating psychotics in small institutions is not new, as 2,161 of Nova Scotia's 2,814 psychotic patients are treated in more than a dozen county homes—each with less than 300 population.

Although the ratio of patients in mental hospital varies from province to province, the Canadian average of 372 per 100,000 (which includes the mentally retarded) is about the same as the ratios in the United Kingdom and in the United States. Most of these hospitalized patients (up to 85 per cent in some provinces) are chronic, and now receive residential care rather than active treatment. Due in part to a lower death rate, especially for tuberculosis, the number of old persons in mental hospitals has increased a great deal during the past 30 years. Since depression and war had stopped hospital construction, by 1945 most Canadian mental hospitals were severely overcrowded. During the past ten years, because of drugs and changing practices, the numbers of patients per 1,000 population in most provinces had declined sharply—in spite of a large increase in admission rates. This ten-year period has seen but little building, partly because of the uncertainty as to what sort of accommodation will be needed for mental patients in future.

The per diem cost for each mental hospital patient varies little from one province to another, despite great differences in the number of hospitalized patients per 1,000, and differences in provincial wealth. From 1937 to 1962 the cost per patient per day increased from about $1.00 to the present national average of about $5.00 a day. In Nova Scotia, where the per diem rate of the Nova Scotia Hospital exceeds $12.00 a day, the total cost keeps to the Canadian average—due to the relatively low expenditure for chronic patients in municipal mental hospitals. All provinces spend more than three times as much per day for each general hospital patient as they do for those in mental hospital.

Regional differences affect the number of psychiatric nursing staff in different parts of Canada, as well as the training they receive. By and large, provinces with small mental hospitals, like Newfoundland and Prince Edward Island, have a higher ratio of nursing staff than do provinces with larger hospitals. In Eastern Canada, the psychiatric nursing staff includes a higher percentage of Registered Nurses than in the West; on the other hand, the four Western Provinces have active staff-training programs within their institutions, and so produce large numbers of mental hospital trained nurses.

What does the future hold for the large provincial mental hospitals? As yet there are no definite clues. There is active, and sometimes acrimonious debate on whether psychotics can best be treated in big mental hospitals, in little mental hospitals, or in units in general hospitals. To throw more light on this question, carefully controlled pilot projects involving all three are badly needed.

(b) *For the Mentally Retarded*

During the past half century, Canada has lagged far behind Britain in developing services for the care and training of the mentally retarded; two Canadian provinces have no separate facilities at all for the retarded, and in two

other provinces the services have scarcely progressed beyond the token stage. Since World War II, parent organizations in all provinces have led pressure groups that have requested more in-patient and out-patient facilities. This pressure has been especially strong in the Maritimes where the residential facilities are particularly limited, and where feelings are generally more emphatically expressed. With its propensity for specialized units, and with more money, Ontario has the most institutions and the most beds for the care and training of the mentally retarded; this includes an interesting research unit under the supervision of the University of Western Ontario.

Parents rather than professionals have forced governments to increase the number of nursery schools for the severely retarded, and as well, to provide counselling services and rehabilitation for the older members of this group. The strength of the movement is illustrated in New Brunswick, which, despite poorly developed social service patterns, now has twelve classes containing 165 severely retarded children. To support these, the Provincial Government each year pays $1,000.00 per classroom with $500.00 for each teacher and $100.00 for each pupil; other provinces have similar arrangements.

Waiting lists of up to 500 per institution (as in Saskatchewan) strengthen the cry for more in-patient services, yet at the same time many believe that an even greater need exists for more day care units, and for more counselling services for parents. Should these counsellors be persons who restrict their activities exclusively to the retarded, or should the parents of the retarded be counselled by public health nurses or social workers who have other duties as well? This relates to the vexing question of how far services for the mentally retarded should be separated from those of the rest of the mentally disordered. Certainly, some parents of the mentally retarded resent having their children dealt with in general psychiatric units; in Halifax, representatives of the CARC requested that the services for retarded children be in the Children's Hospital, rather than in the Mental Health Clinic; yet eliminating one type of segregation by substituting another is not necessarily an advance.

(c) *Community Clinics*

The number of Mental Health Clinics varies from province to province, as does their mode of operation. The spread ranges from Ontario with 34 full-time mental health clinics (plus numerous part-time travelling clinics) to Newfoundland with but one clinic, which is located in its mental hospital with additional sessions in the local general hospitals. Most of the Canadian Mental Health Clinics began—as did their American models—by providing follow-up services for discharged patients, but later like their British counterparts, they added treatment and consultation as well. Most Canadian Mental Health Clinics are now swamped by spiralling demands for treatment, and as a result consultation services suffer. This is particularly true with the child guidance services in which ridiculously long waiting lists have developed.

In the beginning, most clinics were financed by Provincial Governments, but in the larger cities, many clinics have since been set up using municipal or private funds. Increasingly, the clinics have separated from the provincial mental hospitals; this has improved their liaison with the public, but increased the isolation of the provincial institution from its community. With more community identification, the director of the clinic functions increasingly like a private psychiatrist, although unlike the private psychiatrist, he has a psychologist and a social worker to help him. With the trend towards increased government participation in paying for all medical care, there seems to be less reason to

finance out-patient psychiatric service differently from other types of office medical care. Are there still good reasons to differentiate between private psychiatrists and government psychiatrists engaged in community work? Perhaps both should be financed like other medical specialists. Certainly clinic directors should have closer communication with general physicians, who are now requesting the same kind of support from psychiatrists that they get from internists and surgeons.

(d) *Manpower Needs in Psychiatry*

Although mental patients occupy nearly 50 per cent of all so-called hospital beds, less than three per cent of Canada's physicians are qualified psychiatrists. For each 25,000 population there is but one psychiatrist today, and even accepting the most optimistic view of proposals to expand training, it seems unlikely that during the next ten years this ratio can be increased to more than one to 15,000 population. A large percentage of psychiatric posts in Canada are now filled by graduates from foreign medical schools; some of this group are in Canada only because U.S. immigration laws temporarily prohibit their re-entry to the United States. Every year many of these doctors have returned to the United States, and many others are likely to be gone soon. It is a disconcerting, but probably a realistic view to assume that many of this group are in psychiatry chiefly because other medical specialties are less open to them.

The lack of medical staff constitutes the most serious shortage in Canadian psychiatry. From all sides, psychiatrists are pressed to treat neurotics, psychotics, psychopaths, and mental defectives. They are also expected to provide training and orientation for those individuals in the community whose work requires psychiatric understanding; yet such a limited force cannot properly meet such large demands.

Although all provinces are seriously short in the number of psychiatrists, urban centers like Montreal, Toronto and Vancouver are much better off than other areas. With a population of 650,000 New Brunswick should have 35 qualified psychiatrists, whereas actually it has but seven; in other areas the shortage is just as acute. Since there are not enough psychiatrists in Canada today to meet all the demands for treatment, diagnosis and teaching, and since there is no prospect of increasing the number fast enough to make it possible for these demands to be met, ways should be found to make better use of the psychiatrists we now have. Psychiatrists should not spend their time doing what general physicians, nurses, social workers and others can do as well or even better. Each psychiatrist should have more time available to consult with those other professionals who have to work with mentally disorderd people. Qualified psychiatrists should serve primarily as consultants—not as general practitioners engaged in psychiatry. Governments should set up boldly conceived and carefully controlled projects in which psychiatrists provide more consultative and supporting services to the others who work with the mentally ill.

3. Psychiatry in Relation to Other Health Services

(a) *Public Health Services*

In most places, the Deputy Minister of Public Health is responsible for that province's psychiatric institutions and for its mental health clinics. It was hoped that placing the mental hospitals within the Departments of Public Health would improve their status in the community, and as a result, that others working in

the health field would do more for psychiatry; this intention was good, but there is little to suggest that the mental hospitals have benefited by being in the Departments of Public Health. By and large, public health administrators have not known what to make of their huge—and to them indigestible—mental health program. Moreover, always faintly suspicious of public health departments anyway, family doctors tend to be cool towards provincially employed psychiatrists. Although the public's view of psychiatry and of mental health is improving, this improvement probably results more from psychiatry's closer contact with general hospitals, and with general physicians than from its attachments to public health services.

In Britain, consultant services in psychiatry are organized exactly the same as consultant services in other medical specialties, and comparatively speaking, the status of psychiatry and of pyschiatrists is much higher in Britain than in Canada. It would now seem wise to move towards administrative arrangements in which psychiatrists function like other specialists, although until such arrangements become possible psychiatric services (unlike medical, surgical and other services) may have to be part of a provincial governmental department.

There would be more justification for having psychiatric services within provincial departments of health if public health officers and public health nurses made more contribution to the follow up of discharged psychiatric patients, or did more in the community treatment of the mentally disordered; unfortunately, most public health officers and public health nurses have had little to do with psychiatric care. Despite the fact that in eight of ten provinces psychiatric services are wholly within the Department of Public Health—and have been for many years—and despite the fact that next to the need for more psychiatrists, the greatest need in psychiatry is for more help in the community, little direct assistance is provided by the staff of most public health organizations. There are isolated exceptions to this; public health nurses in Prince Edward Island do help with the counselling of parents of the mentally retarded, and public health nurses in Southwestern Ontario participate in the follow up of patients discharged from the Ontario Hospital, St. Thomas.

It would be unfair to suggest that the failure to use public health facilities for community psychiatry should be blamed more on public health administrators than on psychiatrists. With one or two exceptions, no one yet in Canada has demonstrated whether public health nurses could do a good job in community psychiatry, nor has anyone worked out how they might be used. It has been suggested that there should be one public health nurse for each 5,000 population, and that if the public health nurses participated actively in mental health programs, then there should be one for every 3,500. Unfortunately, no pilot projects have been set up to prove or disprove this contention.

Pilot projects should be established to explore better co-operation between public health services and psychiatry. Ways of orientating and involving public health officers in these pilot projects should be worked out. Perhaps the public health unit could include active participation in psychiatry among its other responsibilities, and perhaps more of this type of community personnel is needed for psychiatric follow-up; only controlled experiments will tell whether or not these suppositions are correct. Certainly, in parts of the United Kingdom, the visiting nurses help a good deal with psychiatric problems in the community. Having had some psychiatric training, more than 100 nurses in the city of Edinburgh have psychiatric responsibilities—along with their other duties. An

adequate trial will be needed to determine whether or not this would work as well in Canada.

(b) *General Hospitals*

Canada has nearly 100,000 general hospital beds (more than 5 per 1,000 population)—compared to approximately 70,000 beds for the mentally disordered (3.7 per 1,000 population).

At any one time a number of patients (probably from 5 to 15 per cent of the total) in these 100,000 general hospital beds, have "physical" complaints resulting primarily from mental disorder. Most of the "psychiatric" patients in these non-psychiatric beds suffer from neurotic disorder, although some are depressed and some have mental symptoms due to brain damage. Most of the mentally disordered in general hospitals are cared for by general practitioners, internists and other non-psychiatric specialists, although sometimes psychiatric consultants are asked for advice; most of this group is treated intuitively rather than scientifically, and even though the treatment often turns out well enough, too little use is made of formal psychiatric knowledge.

For the most part, the patients receiving treatment for psychiatric conditions in general medical wards have to be admitted with a non-psychiatric diagnosis—otherwise they would not get in. In Prince Edward Island, however, general practitioners can admit and treat patients with a psychiatric diagnosis, provided that the general practitioner has first discussed the patient with a psychiatrist. It would be useful to carefully evaluate this P.E.I. program, and all other programs in which family doctors, in collaboration with psychiatrists, treat psychiatric patients on medical wards.

Besides the many thousand psychiatric patients treated on medical wards in Canadian general hospitals, more than 2,000 beds in more than 50 general hospitals have been set aside in psychiatric wards. More than 15,000 patients are admitted to these wards annually—more than half as many as admitted to all mental hospitals combined. For the most part, the patients in psychiatric units in general hospitals are treated by physicians specializing in psychiatry; the Directors of a few of these units do invite general practitioners to admit and treat their own patients in the psychiatric unit, in collaboration with a psychiatrist. (The psychiatric ward in the University Hospital at Saskatoon has set aside nearly 10 per cent of its beds for the use of general practitioners.)

In a recent statement, the Canadian Psychiatric Association has officially recommended that all general hospitals of more than 200 beds should have psychiatric wards. The Government of Ontario contributes $8,500.00 per bed for the construction of such units in general hospitals, and there are now seventeen psychiatric wards in Ontario.

During my survey of trends of psychiatric care in Canada, the question arose repeatedly as to whether in the treatment of psychoses, the general hospital is a useful alternative to the mental hospital. Although it has been demonstrated that all types of psychoses (with the exception of the criminally insane), can be treated in psychiatric units in general hospitals, it has not yet been established beyond doubt that this is better than treating the same patients in mental hospitals, a large number of psychiatrists now believe general hospital care is better, but scientific evaluation of this opinion is needed.

In most areas, psychiatric units were intended to supplement the service of a mental hospital. For the psychiatric unit to completely replace the mental hospital would require better organized home-care, day-care, and community follow-up services than any community now has. Certainly some pilot projects should be set up in which all the hospital psychiatric treatment in an area is provided in a general hospital unit. Such a program, if carefully evaluated, could determine the future place of the general hospital in the treatment of the psychoses.

(c) *Non-psychiatric Physicians*

All practising physicians see many patients who are confused, depressed, anxious or dull; depending on the nature of his practice, it is reliably estimated that between 10 and 20 per cent of all who come to a doctor's office each day do so because of an emotional or mental disorder. Whether he likes it or not, the practising physician must handle most of these patients himself, because it would be impossible to refer all of this group to a consultant psychiatrist. If the 15,000 doctors in Canada thus see a total of nearly 75,000 patients each day with psychiatric problems, it is quite obvious that the 200 to 300 psychiatrists available for office treatment could not possibly deal with so great a horde—that would mean 200 patients per day per psychiatrist.

Yet most doctors entering practice in Canada do not expect to assume major responsibility for a large number of people with psychiatric complaints, nor were they adequately trained to diagnose and treat emotional disorder. It is true that since World War II the medical schools in Canada have provided better undergraduate psychiatric education than formerly; this training is superior to that in the medical schools of the United Kingdom and is as good as in most U.S. medical schools. Yet the Medical Council of Canada does not yet recognize the importance of psychiatric problems, or of training in psychiatry, because it has not yet established qualifying examinations in psychiatry as part of the L.M.C.C. Although more than half of all medical school graduates go into general medical practice—where they have to do much psychiatry—yet of all of the specialties, psychiatry is almost the only one in which for those bound for general practice there is not compulsory internship.

Because there are too few psychiatrists, and because the consulting psychiatrists are now so busy, most physicians in practice have little contact with psychiatric consultants. As a result, the practising physician can seldom obtain emergency consultation service. There is a long waiting list for all regular consultations, and consultation opportunities for emotionally disturbed children are almost impossible to get. Many Canadain practitioners complain that written reports from psychiatrists have limited value, yet the practitioner almost never has a chance to talk to the psychiatrist—either by telephone or face to face. When the family doctor refers a patient for psychiatric treatment, this usually means admission to a mental hospital—with its attendant stigma. If he wishes to treat his own psychiatric patient in general hospital, usually the general practitioner cannot arrange admission except by using a non-psychiatric diagnosis.

In all provinces, I was told, both by general practitioners and psychiatrists, that much more must be done to assist the family physician to deal with his psychiatric problems. Many pilot projects should be set up to find new ways of preparing the family physician for psychiatric responsibilities, and to

help him carry these out. Most psychiatrists wanted Dominion Council examinations in psychiatry, and a compulsory internship in psychiatry for all medical graduates. Non-psychiatrists requested that there be more psychiatrists available for consultation services for the family physicians. Family doctors asked for emergency consultations, domiciliary consultations, and for more regularly scheduled Mental Health Clinic services. Many said that psychiatric consultation service should be available in all general hospitals to which general physicians admit patients, and some said that family doctors should be able to admit and treat a number of their own psychiatric patients in general hospital—in collaboration with consultant psychiatrists.

The trend towards early discharge from mental hospital, and towards community treatment of psychiatric patients does put a greater burden on the family physician. Thus, in addition to a readily available consultation service, he needs more help from psychiatrically trained ancillary personnel—including social workers and public health nurses.

4. Voluntary Agencies

(a) *Canadian Mental Health Association*

This is a National Organization of citizens interested in improving mental health facilities in Canada; it has nine Provincial Divisions.

The Canadian Mental Health Association is the successor to the National Committee for Mental Hygiene, which was founded in Canada more than 40 years ago by Dr. C. M. Hincks, Dr. J. D. M. Griffin is the present Medical Director of the National Office located at 52 St. Clair Avenue East, Toronto 7, Ontario.

To finance its activities, CMHA raises funds through annual drives, from private subscriptions, and through contributions from Community Chests. The organization deserves much of the credit for the post-war improvement in public attitude towards psychiatry, and for the reduction of some of the stigma formerly attached to mental hospitals. It has organized public support for better psychiatric services, more research, and for better psychiatric education. It has established and financed many service projects of its own—including volunteer visiting in mental hospitals, White Cross Centers for recreation and information, and grants for psychiatric research.

(b) *Canadian Association for Retarded Children*

This National Organization has Divisions in most provinces. It was organized in Canada after World War II by a group of parents and friends of the mentally retarded; there is a similar organization in the United States.

The Association has established and operated service programs for the mentally retarded (including classes for those excluded from the regular schools), also recreational centers, day-care programs and sheltered workshops.

Pressure from this Association has inspired Governments to spend more money on the education and training of the retarded and for counselling services for parents. Recently the trend in the policies of the Association has been towards co-ordinating existing services in education and health to improve the lot of the mentally retarded. Thus the CARC seems likely to continue to act as a goad to make governments do more to meet their responsibilities for the mentally retarded.

5. Special Problems

(a) *Child Psychiatry*

Of all the psychiatric services in Canada, the psychiatric services for children are the least well-defined and the least uniform; no two provinces have comparable facilities for the diagnoses and treatment of disturbed children. In some centers most disturbed children are seen in adult clinics, whereas other areas, like the Province of Alberta, have travelling child guidance clinics. Newfoundland opened its first child guidance clinic in 1963. Ontario, on the other hand, has for several years had child guidance clinics under diverse auspices; also at Thistletown the Government of Ontario has set up a 65-bed research and treatment unit for emotionally disturbed children.

The sponsorship of psychiatric services for children varies a great deal. In Manitoba the School Board operates the Child Guidance Service of Greater Winnipeg, which has an annual budget of $375,000. Elsewhere some child psychiatric services come under city health officers—whereas others are operated by school health programs; some are privately sponsored. Some paediatric departments, such as that in the Hospital for Sick Children in Toronto, operate their own child psychiatric services. Some child guidance clinics work closely with teachers trained to diagnose mental disorders in children.

Although most child guidance services do not feature problems of retardation, a new 240-bed child psychiatric center, being built in Saint John, New Brunswick, will admit both emotionally disturbed and mentally retarded children.

Despite an increasing number of child psychiatrists devoted to improving services, it is apparent that the present situation of child psychiatry in Canada is chaotic indeed. No blueprint now exists to guide child psychiatrists in estimating the needs for in-patient and out-patient services for emotionally disturbed children. Pilot projects should be set up to determine what facilities a community requires to deal with the mental and emotional problems of its children.

(b) *Psychiatric Services for the Aged*

Patients over 65 occupy 35 per cent of Canada's 55,000 beds for the mentally ill—even though almost everyone agrees that most old people should not be kept in these institutions. Mental hospital administrators claim that most senile patients could be better cared for elsewhere. Most families object to sending their slightly confused aged relatives to mental hospitals—especially since most go to these mental hospitals simply because there is nowhere else to go.

Two provinces (British Columbia and Alberta) have set up separate institutions for psychotic old people; although such institutions do have some advantages, they fail to meet the sick old person's need for specialized medical attention. It is now agreed by most psychiatrists, by social workers, and by others in the field, that as far as possible, mentally impaired old people should be kept in the community—or at least out of mental hospital. With this in mind, the British admit aged persons with mental symptoms to their geriatric services in general hospital. Here geriatricians, using psychiatrists as consultants, diagnose, treat and try to rehabilitate these confused old people.

I discussed the needs of the mentally ill old with interested persons in all parts of Canada. I talked with general practitioners and psychiatrists; these

discussions have resulted in the pattern of care suggested below. The recommendations could certainly be adapted to the different situations in different parts of the country.

I would sum up my conclusions as follows: old people with mental disorders should be investigated in general hospitals, preferably in units that have competent internists interested in geriatrics, and where there are psychiatrists readily available for consultation. A small percentage of the mentally ill old people—usually those with acute depression or disturbed behaviour resulting from brain damage—would ultimately require admission to a specialized psychiatric facility (also in a general hospital). Chronically ill old people who require prolonged specialized care for mental as well as physical disorders should be kept in long-stay units near general hospitals, where psychiatrists and internists would be available. As far as possible, family doctors should remain in contact with their patients throughout the entire span of investigation and treatment.

Whenever, for physical or mental reasons, an old person requires more personal assistance than could be given at home (yet does not need constant attention from physicians or trained nurses) he should be admitted to a nursing home—preferably one that accepts both the physically handicapped and the mentally handicapped. Homeless old people with mild mental impairments, who could be kept at home if they had a home, should be admitted to homes for the aged whenever no other alternative exists. These homes could be operated by municipalities or by charitable organizations, and could comfortably house many patients now in Provincial mental hospitals.

With the arrangements outlined above, with the support of home care, with day care and with help from general practitioners interested in geriatrics, no mentally disordered old person need be kept in Provincial mental hospital.

(c) *Alcoholism*

According to the formula devised by the late Dr. Jellinek, Canada has more than 200,000 persons seriously handicapped by alcoholism. All mental hospitals and psychiatric units admit and treat some alcoholics—with alcoholics making up 7 per cent of all mental hospital admissions in Canada (as high as 15 per cent of all psychiatric admissions in the Maritime Provinces).

Several provinces have established Alcoholism Foundations, operated under joint government and private auspices. The most comprehensive program is that of the Alcohol and Drug Addiction Foundation of Ontario. Because of its research into problems of alcoholism (and into patterns of providing service) it justly deserves the respect it has gained in Canada and elsewhere. Its pattern of service for dealing with alcoholics seems most appropriate. Instead of attempting by itself to provide complete service to all of Ontario's alcoholics, the Foundation plans to operate research and demonstration services that would look after only a small percentage of the Province's alcoholics. Responsibility for most of the alcoholics would then remain with general practitioners, general hospitals, and local social services. The Alcoholism Foundation would provide consultation and planning services, and help to co-ordinate the efforts of existing community programs.

This pattern presents a most sensible approach to the problem of alcoholism; unfortunately, such planning and co-ordination is lacking in most parts of

Canada. If the plan of the Ontario Foundation is to be followed generally, then general practitioners and general hospitals will have to play a greater role in the treatment of the acute alcoholic patient.

(d) *Psychiatric Social Workers*

With the trends in psychiatry pointing towards caring for most of the mentally ill in the community, there is an increasing need for community workers skilled in psychiatry. Unfortunately, there is a serious shortage of social workers in psychiatric programs throughout Canada. Newfoundland has three or four social workers attached to its mental hospital; P.E.I. has five workers between its hospital and the community clinics; even Ontario, with 138 social workers in its institutions, is considered woefully understaffed. Moreover, the Canadian Schools of Social Work promise no great improvement in this situation in the near future.

During the survey, many persons with whom I talked thought that trained psychiatric social workers should not concentrate their efforts on social case work. Perhaps their services could be better used if they spent more time acting as consultants and as advisors in follow-up programs in which they supported public health nurses, V.O.N.'s and other community workers who would then deal directly with psychiatric patients and their families.

(e) *Psychologists*

In each of the ten Provinces, psychologists are employed in mental institutions and in clinics; their activities include diagnosis and treatment, as well as research and teaching.

The number of psychologists employed varies from 14 in Saskatchewan and 15 in New Brunswick, to 88 in the mental hospitals and clinics of the Province of Ontario. Many psychologists appeared to be discontented with their role in Canada's mental health program—and with good reason.

(f) *Private Practice of Psychiatry*

The number of private practitioners in psychiatry in Canada varies from Prince Edward Island, Newfoundland and Saskatchewan with 1, 2 and 3 respectively, to Ontario with 85. In some provinces, the Provincial Government will pay a basic stipend to a psychiatrist for administrative and clinic duties, and then that psychiatrist earns the balance of his income through fees for consultation and treatment in private practice. This combination of salaried service and private practice offers the best chance of securing consultant psychiatrists for the many isolated areas that could not support a specialist in private practice alone. Moreover, it is helping to close the gap that has long since existed between psychiatrists in private practice and those in government salaried posts.

(g) *Rehabilitation*

Almost every patient treated in a psychiatric facility presents a problem in rehabilitation; yet little has been done to enable psychiatrists to use the administrative structure being set up to rehabilitate the physically ill, and almost no advantage has yet been taken of the Federal Government's current interest in rehabilitation. For the most part, after treatment psychiatrists discharge their patients from hospital with too little attention paid to their

chances for future employment. In part, this neglect results from the traditional isolation of the mental hospital, and in part from the physician's too frequent aversion to concerning himself with the social problems of sick people.

In Britain, many mental hospitals make contacts with business firms that can gainfully employ large numbers of chronic patients. In Canada I saw one or two hospitals (one of these at Weyburn, Saskatchewan) where this was being done to a small extent; unfortunately most industrial therapy in Canadian mental hospitals still consists of unpaid work in the maintenance services of these institutions. A few mental patients can be admitted to Canada's tragically few sheltered workshops, provided that it is clearly understood that these patients soon will be able to enter competitive employment in the community; there is no provision in Canada for sheltered workshops which would permanently employ those with chronic mental handicaps. As a result, many patients now leave mental hospitals only to remain in continued idleness on an assistance income provided by municipal relief.

Why shouldn't the state or private organizations provide permanent sheltered employment in the community for patients with chronic mental handicaps? This could be done by establishing sheltered workshops to which many patients could go after discharge from mental hospital. Presumably such patients would continue to receive the same basic municipal relief or other pension that they would have received if they had remained in idleness; the additional remuneration from the sheltered workshop would act as an incentive to do work that would be both productive and therapeutic.

(h) *Forensic*

Unfortunately, during its transition from a custodial to a therapeutic role, the mental hospital has retained a legacy dating back to when it was considered a place in which to lock up dangerous people; this legacy includes those mentally ill persons who, under a provision of the Criminal Code, have been committed to mental hospital because they have been accused of crime or have been convicted of one.

Psychiatrists have had a long and legitimate interest in the mental state of those charged with crime. In Canada this has led to the formation of a forensic clinic in the Toronto Psychiatric Hospital, to which each year magistrates send more than 300 persons for psychiatric evaluation. These are individuals charged with criminal offences, but whom the magistrate suspects may be mentally ill.

Courts and those who administer prisons have long since used the provisions of the Criminal Code to transfer to mental hospital persons found mentally "unfit to stand trial", or found "not guilty because of insanity", or who have developed mental disorder while serving sentence. Yet many of these mental hospitals have only just managed to unlock their doors, and to send to such hospitals patients involved in aggressive antisocial acts creates serious security problems. Most Provincial hospitals have a number of such patients—for example, 60 of Saskatchewan's 4,500 institutionalized mental patients are held on Lieutenant-Governor's warrants.

Most hospital administrators object to admitting patients on Lieutenant-Governor's warrants to Provincial mental hospitals; most of these administrators believe that the Departments of Justice and Reform Institutions should establish psychiatric services either within their correctional institutions, or adjacent to

them. Here psychiatrists employed by the Minister of Justice could treat mentally disturbed patients within the penal institution. Not only would this change remove a serious problem from the community's psychiatric wards and mental hospitals, but such experience in administering psychiatric treatment could also give penitentiary administrators badly needed insight into human behaviour.

It is likely that such a step would require some changes in the Criminal Code; perhaps a start could be made by having the Federal Department of Health and Justice set up an inter-departmental committee to study how best to make these changes.

(i) *Legislation*

The newer philosophies in psychiatric treatment described above are just beginning to be translated into legislation. In line with trends towards community treatment in Canada, the Province of Saskatchewan has produced an Act quite similar to the Mental Health Act of 1959 in Britain. This makes informal admission possible for most patients. When the symptoms of the illness are such that the patient must be admitted on certificate, then the Act requires periodic reviews of the patient's condition. After this review he is either placed on informal status, or else a renewal certificate must be made. Under the Saskatchewan Act, the rights of the patient are protected by an Appeal Board.

Other provinces are making or considering legislative change. Alberta has a committee studying proposals for a new Act; since Alberta's present legislation still requires a magistrate's approval for the mental hospital admission of all committed patients, some change does seem indicated.

To a great extent, legislation reflects public attitude, and the increasing acceptance of mental disorder by the public now makes it possible to replace most obsolete legislation with laws that will permit the mentally ill to be treated more like other sick people.

(j) *Medical Education in Psychiatry*

All Canadian medical schools have Departments of Psychiatry, and all provide psychiatric instruction to under-graduates during most of the medical years. Unfortunately, the Medical Council of Canada has not yet seen fit to require an examination in psychiatry for the LMCC.

All Canadian medical schools participate in post-graduate psychiatric education, which is organized under the auspices of the Royal College. Each medical school has an affiliated network of facilities that enables the candidate to receive a broad training experience. Two of the four training years must be spent in the geographic area of the University. The remaining two years can be spent in a variety of teaching situations—including one year in a Provincial mental hospital. If a candidate has satisfactorily completed a four-year training program that has been approved by the Royal College of Physicians and Surgeons of Canada, he then is eligible to write either the Fellowship or the Certification examination.

(k) *Research*

Mental disorder confronts the people of Canada with a great human problem about which too little is known; this alone would warrant much research into

cause and treatment of mental illness, and much better evaluation of all psychiatric services.

The fact that Provincial governments in Canada spend more than $100,000,000 annually in the direct treatment of the mentally disordered, and the fact that the indirect cost to the public is many times greater, seems to clearly indicate the need for spending much more time and money on research, yet little research is being done.

Each Canadian university medical school does have programs of psychiatric research that vary from almost none to a limited amount. One Provincial government (Saskatchewan) spends a moderate sum on research in its provincial institutions. Researchers from Cornell University have combined American and Canadian Federal funds in an extensive epidemiological research in western Nova Scotia.

There is a need for carefully planned expenditures of large sums of money to scientifically learn more about the nature of the mental disorders, and how best these can be dealt with. One urgent need is for detailed research on the amount of mental disorder in a typical population—combined with a closer look at sociological factors. Such research could best be carried out in a community that is relatively isolated from its neighbours; Prince Edward Island and Newfoundland have been suggested as areas that meet this criterion. There is much interest in such a project, but so far no plan has been worked out to finance a study of this kind in either of these two provinces—or elsewhere.

CHAPTER 2

TRENDS IN PSYCHIATRIC SERVICES IN NEWFOUNDLAND

1. Introduction (1) (2)

In assessing psychiatric services in Newfoundland today, several features peculiar to that Province must be kept in mind. No other Province in Canada has to contend with such geographic handicaps. Newfoundland covers an area of 156,115 square miles, with only 42,734 square miles of this comprising the Island. Because the Island's deeply indented coast line was originally settled by fisher folk clustering around widely separated sheltered bays and harbours, travel and communication have been difficult. Almost all of the Province's psychiatric services are situated at St. John's in the South East corner of the Island. These services are readily accessible to the more than 200,000 persons living on the Avalon Peninsula, but not to an equal number of persons scattered throughout the rest of the Province. Travel is by air, road, train, and ship, and all four methods present problems. To make services more readily available, some decentralization will be necessary; yet even this presents difficulties because, outside of the Avalon Peninsula, few areas have enough population to warrant setting up special services.

Except in St. John's and in a few other centers such as Corner Brook and Grand Falls, the population is widely dispersed; so the Province had to build cottage hospitals and employ physicians to provide these remote areas with basic medical services. Now the Government must devise a means of providing psychiatric services to these separated units.

Psychiatric services in Newfoundland have had a late start due to a combination of circumstances including financial difficulties in the thirties, the years of Commission Government, and the late development of Newfoundland's rather abundant natural resources. Newfoundland does have the distinction of having opened one of the first mental hospitals in British North America—at St. John's in 1845; but for the reasons mentioned above, its psychiatric program developed very little until after the Second World War, and after the Province joined Confederation. During recent years, Newfoundland has been fortunate in its psychiatric leadership, and now under the direction of Dr. C. H. Pottle, it is making the most of a difficult situation.

2. Psychiatric Services (3) (4) (5)

(a) *For the Mentally Ill*

In 1961, there were 971 patients (including mental defectives) in institutions in Newfoundland—with 663 of these in the Hospital for Mental and Nervous

Diseases at St. John's. Sometimes referred to as Waterford Bridge Road Hospital, this building is on the site of the original mental hospital, and is the focal point of the Province's psychiatric program.

There are an additional 188 psychiatric beds at the nearby Topsail Road Hospital—a former TB institution. Gradually the Topsoil Road unit is being converted into a geriatric-psychiatric service. It now has a senior resident, and an organized consultation service with part-time staff including an internist, an orthopaedic surgeon, and a genito-urinary specialist; a part-time general practitioner may be added soon. At the Topsail Road location, there is also a detached unit called the Annex that houses 40 ambulatory old people.

Finally, located on the grounds of the General Hospital, there is a 120-bed building for mental patients; it is somewhat unsuitably known as the Psychiatric Unit. At the time of my visit in October 1962, the Psychiatric Unit contained mostly mental defective patients; it will likely be abandoned soon.

The Province's 971 psychiatric beds (including those for the mentally retarded) provides Newfoundland with 202 psychiatric beds per 100,000 compared to 369 per 100,000 for the rest of Canada; Newfoundland also has 79 first admissions per 100,000 compared with 151 admissions per 100,000 for the rest of Canada. Twenty-five per cent of the Province's first admissions come from St. John's, although that city has only 18 per cent of the total population in the Province. This shows how distance and travel difficulty influence the number of admissions.

All of the Province's psychiatric patients are admitted to the Waterford Bridge Road Hospital, which has two active admission units; most of these patients have been certified as mentally ill. Because of tedious travel for patients from outside the Avalon Peninsula, there is a tendency to send only the most severely ill.

Since difficult travel impedes trial leaves, and since most communities outside of St. John's lack resources to follow up mentally handicapped people, the Hospital for Mental and Nervous Diseases has accumulated a high percentage of long-stay patients. According to an estimate by Dr. Pottle, 30 per cent of the hospital's population is made up of aged people, 35 per cent of schizophrenics, and 20 per cent are mental defectives; thus 85 per cent of the patients receive mostly custodial service. This makes clear the need for an alternative plan of providing long-term care. A logical answer would be to decentralize the care of the chronically ill by placing such patients in facilities in other parts of the Province, where they would be nearer home. Not only would this make it easier for distant relatives to visit, but also it would make it possible for more patients to return to the community.

Newfoundland provides the highest staff-patient ratio of any psychiatric service in Canada, having 659 staff per 1,000 patients—compared to 402 per 1,000 for hospitals in the rest of the country. This results partly from the practice followed by areas outside of the Avalon Peninsula of sending only their sickest to hospital; in part it is an artifact because the 659 established posts include staff working in day-care, out-patient, and other facilities associated with the hospital.

All the doctors employed in psychiatry are in the St. John's area. They total a dozen physicians and, with one exception, are either qualified as specialists, or

in training. The Hospital for Mental and Nervous Diseases has a well-organized resident training program, which is fully integrated with resident training at Dalhousie University; residents spend two of their four training years at the Hospital for Mental and Nervous Diseases. They receive daily lectures, plus supervised experience, with further refresher courses to prepare for certification examination. Members of the University teaching staff make regular trips from Dalhousie University to St. John's; the St. John's portion of the training is under a full-time Director.

The Hospital for Mental and Nervous Diseases has an establishment for 60 registered nurses, although usually not more than 40 of these positions are filled at any one time. All of the registered nurses coming on staff must take one year of training in psychiatry; there are also courses for both male and female nursing assistants, and about 150 nursing students from general hospitals affiliate at the mental hospital each year. The hospital usually has three or four qualified social workers on staff plus two social work assistants.

What does the future hold for the Waterford Bridge Road Hospital? Almost certainly decentralized services will be set up in other parts of the Province and this will result in psychotic patients from outside the Avalon Peninsula being cared for near their homes. Whether the Hospital for Mental and Nervous Diseases will still continue to care for the psychotics from the Avalon Peninsula will depend on the degree to which future psychiatric treatment services develop in the General Hospital, in Grace Hospital, and in St. Clare's Mercy Hospital. Presumably, these three institutions could create sufficient accommodation in psychiatric units so that it would no longer be necessary to admit any acute patients to the Waterford Bridge Road Hospital. It would be wise to establish psychiatric services as pilot projects in at least one of these three general hospitals as soon as possible. This would reveal whether or not the big mental hospital should be allowed to run down, and thus be replaced by expanded community services based on units in the three general hospitals.

Pilot projects providing hospital treatment for psychotics should be set up in one or more of the general hospitals outside St. John's; this will be discussed in a later section of this study.

(b) *Mental Retardation* (5)

According to accepted norms, with a population of more than 450,000, Newfoundland would have at least 13,000 persons with I.Q.'s less than 70; yet there are now fewer than 300 mentally retarded patients in the provincial institutions. This means less than 600 mentally retarded institutionalized per 1,000,000 population, compared, for example, to Ontario which has more than 1,500 mentally retarded persons per 1,000,000 in its institutions. This low rate of hospitalization would not necessarily be bad if the Province provided adequate services to help in the diagnosis, care and treatment of the mentally retarded in the community; unfortunately, this is not so. Each year about eight mental defectives per 100,000 are admitted in Newfoundland, compared to 22 per 100,000 in the rest of Canada. St. John's does have a good foster home-care program, with, in 1963, 37 mentally retarded persons being boarded out in the St. John's area—besides 137 mentally ill also boarded out.

It is unfortunate that the services for the mentally retarded are concentrated in the St. John's area. These services should be decentralized, starting probably with a unit in the Grand Falls—Gander area and with another near Corner-brook. Services for the retarded should be in close liaison with the psychiatric units scheduled for general hospitals in these areas.

Decentralization of the care of the retarded would keep the patients closer to the community, and in addition provide counsellors close at hand for those parents who chose to keep their retarded children at home. This consultation service would also be available to physicians, public health nurses and to school teachers. Such decentralization would encourage close liaison between parent groups and those working with the retarded; this should lead not only to better medical care for the severely retarded, but also to better education, training and sheltered occupation for those with less severe retardation. To a great extent, parents of the retarded living in the most remote areas have to depend on the support from the doctors and nurses manning the outpost hospitals, and on support from the school teachers; these professionals, in turn, must receive more instruction and more consultative help on mental retardation.

Apart from the Provincial Government services for the mentally retarded described above, the Newfoundland Association for the Help of Retarded Children operates six schools or classes for trainable and educable children, with a total of 96 children and 15 teachers; all but one of these are outside St. John's.

(c) *Community Psychiatric Services*

At present, all of the Province's mental health clinic services are in the St. John's area. There is a full-time clinic at the Hospital for Mental and Nervous Diseases which, besides providing consultation and treatment services for patients living in the Avalon Peninsula, is used by doctors from remote areas. Often when a referring doctor is uncertain about a patient's need for admission, he sends this patient to the Mental Health Clinic at Waterford Bridge Road Hospital, and the clinic staff decides.

Two half days weekly, a psychiatric team from the Hospital for Mental and Nervous Diseases holds clinics at the provincially operated General Hospital. This clinic works closely with the day-care program at the Waterford Bridge Road Hospital. A psychiatrist in private practice, together with a neurologist, operates a seizure clinic at the General Hospital. The day treatment center at the Waterford Bridge Road Hospital opened in 1947; it was one of the first units of this kind anywhere.

Out-patient psychiatric services for diagnosis and consultation should be established at all three St. John's Hospitals, and in leading medical centers in other parts of the Province. Pilot projects providing such services should be developed soon in the Gander–Grand Falls area, and at Cornerbrook; later consultants could be based on St. Anthony's and at Twillingate, and also at Clarenville—if a general hospital is built there. Having such consultation services available would help practising physicians, public health nurses, and others dealing with the mentally disordered.

3. Psychiatry and Other Health Services

(a) *General Hospitals* (1) (2)

Since all general hospitals (often under protest and sometimes in ignorance) admit large numbers of patients suffering principally from mental disorder, it is important to know something of the general hospital services in Newfoundland. In 1961, the Province had 1,924 general hospital beds (not including bassinets); half of these were owned and operated by the Provincial Government.

The Government hospitals included the 470-bed general hospital in St. John's with the remaining beds being distributed among eighteen cottage hospitals throughout the rest of the Province. The cottage hospital program began in 1930, in the midst of Newfoundland's great financial and political crisis. To provide services for its isolated citizens, the Province built small decentralized cottage hospitals, and staffed these with Medical Officers and nurses—paid with provincial funds. To enroll in the cottage hospital program, each family must pay an annual $10.00 fee, and more than 45 per cent of the Province's population receives its medical care through this scheme. As yet, none of the cottage hospitals, and none of the general hospitals outside of St. John's have had locally based psychiatric consultation services. All psychiatric patients from these centers are referred to the St. John's area for consultation. Large general hospitals are now being built both at Gander and at Grand Falls, each of which will have a psychiatric unit. In order to secure a psychiatric consultant for each unit (and for psychiatric units subsequently built in other hospitals outside of St. John's) the Provincial Government may have to pay a basic subsidy which the psychiatrist could supplement through private practice. Rather than confining these 20-bed psychiatric units to admission by specialists, it is suggested that general practitioners in the area be allowed to admit and treat their own psychiatric patients in these psychiatric departments—as long as they work closely with the consultant psychiatrist in charge of the service. Having general practitioners admitting and treating in such units would compensate somewhat for the shortage of psychiatrists, and would require psychiatrists and general practitioners to work closely together to their mutual advantage.

If pilot projects set up in the Gander, Grand Falls, and Cornerbrook Hospitals prove successful, similar units should be considered for St. Anthony's, Carbonear and Twillingate—and also Clarenville—if a general hospital is built there. These units should not be set up as acute units that send long-stay patients on to St. John's; on the contrary, each should provide an entire range of psychiatric service in its own community. To do this would require some beds for long-stay patients needing continued hospitalization, and also require close liaison between the staff of the unit and those in the community who could care for the mentally disordered outside of hospital, especially the brain-damaged, the chronic schizophrenics, and the mentally retarded. This would make necessary better organized community services, and better integration of these with general hospitals; general practitioners, public health nurses and other helpful people would have to work closely with this community psychiatric service.

(b) *Non-psychiatric Physicians* (2)

With the possible exception of specialists in radiology and pathology, all practising physicians must diagnose and must treat patients with emotional disturbances; for this reason it is important to know something of the non-psychiatric physician services in Newfoundland. The Province has about 300 physicians, more than half of whom are in the St. John's area. Since the St. John's physicians serve persons living in the Avalon Peninsula with its relatively heavy population, and since these doctors include most of the consultants accepting referrals from the rest of the Province, more than half of Newfoundland's doctors are in the St. John's area. According to the annual report issued by the Department of Health in 1961, 134 of Newfoundland's 298 doctors were located outside of St. John's; 73 of these were employed as Medical Health Officers—44 in cottage hospitals, and 29 as District Medical Officers. The 44 cottage hospital physicians are on full-time salary, but many have consultant

or private practice privileges; the 29 part-time Medical Officers of Health derive income mainly from private practice.

Unfortunately, the 73 Medical Officers in cottage hospitals, and in district employment, have no psychiatric consultants available except those in St. John's; the same applies to the 61 physicians outside St. John's who practise on their own.

Since, whether they like it or not, the 134 physicians practising outside of St. John's have to see patients with psychiatric disorders, it is important that they receive readily available assistance from specialists in psychiatry without having to send patients to St. John's for help. To start with, consultant psychiatrists should be located at Cornerbrook, Gander and Grand Falls, and as more psychiatrists become available, consultant services should be established in other centers like St. Anthony's, Twillingate, and Carbonear. The main task of these consultant psychiatrists would be to support the physicians who actually diagnose and treat the mentally disordered—not to take psychiatric patients away from the care of their general practitioners.

(c) *Nursing*

Newfoundland has 857 registered nurses—597 of these are located in the Avalon Peninsula. Not including the 60 established nursing positions at the Waterford Bridge Road Hospital, the Province employs 138 nurses; this group has to man the cottage hospitals, and to perform the other tasks that public health nurses are wont to do.

Because of the difficulty transporting mentally disordered people to central psychiatric facilities, and because the doctors at the cottage hospitals are rarely skilled in psychiatry, and because consultant psychiatrists are almost never seen in outpost hospitals, it is important that these nurses be able to deal with many mentally disordered patients. When no alternative exists, nurses usually deal well with anxious, confused and depressed patients, but if there is a psychiatric unit nearby the general nurse loses confidence in her ability to cope with the psychiatric patients, and wants the patient transferred; this is unfortunate. More than most provinces, Newfoundland needs to prepare all of its general nurses to deal with psychiatric problems. Not only should they be able to nurse mentally disordered persons in general hospitals, but also they should participate in the home visiting and counselling of parents of the mentally retarded.

4. Special Items

(a) *Child Psychiatry*

Early in 1963, the first child psychiatric clinic in the Province was set up in St. John's. Obviously, such consultation services should be duplicated as soon as possible, at the other central points in the Province, including Grand Falls and Cornerbrook.

(b) *Aged*

At the present time, the Topsail Road unit is being converted into a geriatric-psychiatric service; adjacent to it is a 40-bed annex for ambulatory old people. Compared with most other provinces, Newfoundland has a lower ratio of old patients in mental hospital—15 per 100,000 compared to 29 per 100,000 for

the rest of Canada. There are fewer old people in Newfoundland's mental hospital because it is so far from the homes of so many. This small number of old patients in hospital would not be altogether bad if there were more facilities available in the community to care for old people with mild mental confusion. There are four in-patient facilities in St. John's (other than mental hospital) for the aged. These are operated by church and welfare organizations and accommodate a total of 482 old people. The Province needs more chronic care units, including homes for the aged. It would be possible to treat more confused old people nearer their own homes if decentralized psychiatric services were established in places like Cornerbrook and Gander.

5. Conclusion

Newfoundland has fewer psychiatric beds, and less community psychiatric services than any other province; in developing psychiatric services, Newfoundland, compared to other provinces, has also been bedevilled by a late start, and is having greater transportation and financial problems. To a point this lack of psychiatric services outside the city of St. John's can be turned to advantage in planning for a province-wide program based on present day concepts. The Director of Mental Health is now working out decentralized consultation treatment services in parts of the Province where psychiatrists have never been located before. He should be able to integrate the psychiatric efforts of family physicians and nurses.

What is now needed most urgently is to set up pilot projects in two or three centers outside St. John's. These could not only point the way to future services in the Province, but also provide a most useful epidemiological research program—helpful to psychiatry in Newfoundland and in all of the rest of Canada.

REFERENCES

1. Miller, Leonard, "History of Health Services", *Canadian Hospital*, February 1962, Vol. 39, No. 2, p. 47.
2. Miller, Leonard, "College Hospital System", *Canadian Hospital*, February 1962, Vol. 39, No. 2, p. 48.
3. *Annual Report of the Department of Health*, St. John's, Newfoundland, 1960.
4. *Annual Report of the Mental Health Services*, St. John's, Newfoundland, 1961.
5. *Mental Health Statistics, 1961*, Dominion Bureau of Statistics.

CHAPTER 3

TRENDS IN PSYCHIATRIC CARE IN NOVA SCOTIA (1) (2) (3) (4) (5)

1. Introduction

In Nova Scotia, psychiatry is different. All other provinces (like all Western Countries) follow the traditional pattern of placing their mentally disordered in large segregated institutions; Nova Scotia keeps its long-stay mental patients in county homes, each with an average of 250 beds. In other provinces, the Public Health Departments usually operate the community psychiatric services; in Nova Scotia this operational responsibility has cleverly been placed with local authorities, even though most of the operational funds come from a central source. This Nova Scotian streak of originality provides a refreshing variation from the usual model of psychiatric organization, and offers a chance for useful comparison of differing patterns of psychiatric service.

In Nova Scotia, interest in psychiatry is more intense than in most other parts of Canada. Most Canadians have a lackadaisical approach to psychiatric issues—but not the Nova Scotians. Here there is a healthy disagreement on many psychiatric questions; although most of their leaders in psychiatry agree that psychiatric services need changing, they disagree vigorously on the form this change should take. This disagreement provides a useful stimulus towards trying out new approaches, and partly explains why psychiatry in Nova Scotia is different.

Geography often contributes to the form that psychiatric organization takes. With 723,000 people living in an area of 21,000 square miles, Nova Scotia has the greatest concentration of population of any province in Canada—excepting Prince Edward Island. With 35 persons per square mile, the population density is six times the Canadian average, and ten times the density in Newfoundland and on the Prairies. This makes operational research easier, as, without the handicaps of distance, it is easier, for example, to experimentally compare centralization with decentralization.

As in other Maritime Provinces, the administrators of psychiatric programs in Nova Scotia must scramble for their fair share of a limited supply of dollars. This tends to increase dependence on Federal assistance, but does not lessen the spirit of independence when conflict arises over what to do with this assistance. It is interesting (but undoubtedly purely coincidental) to note these patterns of originality, of independence, and of vigorous involvement almost to the point of contentiousness, occurring in a province whose population has the highest ratio of Scottish ancestry of any part of Canada.

Nova Scotia has officially provided 2,814 beds for its mentally disordered. These include 535 beds in the Nova Scotia Hospital in Dartmouth, 2,161 beds in the Municipal Mental Hospitals, and 151 beds for mental defectives in the Nova Scotia Training School at Truro (under the Department of Social Welfare). This provides Nova Scotia with 390 psychiatric beds per 100,000 compared to 339 for the Canadian average.

The rate of first admissions in Nova Scotia is a little lower than the Canadian average with 126 per 100,000 population compared to the rest of Canada at 142; this ratio probably reflects the tendency in the Municipal Mental Hospitals towards long stay.

2. The Nova Scotia Hospital (6)

This 535-bed mental hospital lies across the water from Halifax at the mouth of the harbor. The government built this institution in 1858, partly as the result of the pressure put on the legislature by the ubiquitous Dorothea Dix. She receives the credit for selecting the original name—Good Hope Asylum, which, in 1901, was changed to the Nova Scotia Hospital. (I understand that Nova Scotia was the first Canadian province to use the word "hospital" as a euphemism for asylum.)

The Government of Nova Scotia tries to restrict the Nova Scotia Hospital to treating only acute mental disorder; in this way, this hospital differs from all other mental hospitals in Canada—all of which house some chronic patients. The Nova Scotia Hospital admits approximately 1,400 patients each year—less than 20 per cent on a voluntary basis; the balance are certified, transferred from other institutions, or come on a magistrate's warrant. By regulation, the hospital refused to admit mental defectives, and, in theory, patients can be kept only while improving or deemed still likely to improve, although patients on Lieutenant-Governor's warrants must remain indefinitely.

The hospital discharges home more than 80 per cent of those it admits, and transfers each year the remaining more than 200 patients to municipal mental hospitals; chronic schizophrenics and brain-damaged people make up most of these transfers. Once the superintendent has declared the patient chronic, and ready for transfer, then the county must accept him or pay the per diem rate at the Nova Scotia Hospital. This per diem rate is $15.10 a day, compared to an average per diem of $3.58 a day in all Canadian mental hospitals; it more closely approximates the average of $17.24 a day in all Canadian general hospitals.

The relatively high per diem rate at the Nova Scotia Hospital reflects not only the highest rate of turnover of any mental hospital in Canada, but also the best staff–patient ratio (620 staff for 535 patients). This staff includes 19 physicians—13 of whom are trained in psychiatry. There is an average of about 90 registered nurses on staff, many of whom are graduates of a three-year R.N. training program based on the Nova Scotia Hospital. (The institution provides two of these training years—the third is an affiliation in a general hospital; about 20 to 30 students graduate annually from the program.) About 75 nursing students from general hospitals affiliate each year at the Nova Scotia Hospital. There are nine social workers (an unusually high ratio for a mental hospital) and four psychologists.

A casual visitor to the Nova Scotia Hospital forms the impression that despite the concentration on comparatively short admissions, this institution functions like most mental hospitals in other provinces; moreover, it faces similar problems. Efforts to open the doors are frustrated in part by the presence in the hospital of a number of patients previously charged with crime. These include (a) those on 30-day observation at a magistrate's request, (b) patients found unfit to stand trial, and (c) those found not guilty because of insanity. Alcoholism is a fairly acute problem with about 160 of the 1,400 annual admissions presenting severe alcoholic problems.

A one-day visitor could not hope to adequately evaluate the Nova Scotia Hospital or the part that it now plays (or will play in the future) in the province's program of looking after mentally disordered people; nonetheless, certain questions stand out. Can even a good mental hospital, one with the excellent staff that this one has, make its best contribution in a state of semi-isolation—medically speaking? Would not acute patients from Cape Breton, from Yarmouth, and from Truro and elsewhere in the province be better treated in their own medical treatment centers? Would not better contacts with patients' relatives and family physicians be maintained if the Nova Scotia Hospital looked after only the patients from the Halifax area, or possibly only from Dartmouth? Might not the results be better if it were possible to use part of the present buildings to house a general hospital serving the Dartmouth area? Would it not be better to encourage private practitioners of psychiatry to admit and treat their own patients in the Nova Scotia Hospital, even though this might create difficult administrative problems? Similarly, could not local general practitioners acquire more interest and understanding of psychiatric problems if they too admitted and treated their own psychiatric patients in this institution? These and other questions swirl about the future of the Nova Scotia Hospital. Obviously they cannot be settled by argument; perhaps there should be a scientific evaluation of the clinical results, and the emotional reaction of friends and relatives to treating acute psychiatric patients in a separate institution. Any doubts that one may entertain about the suitability of the present method of providing treatment services for Nova Scotia's acute psychotics should not detract from the fact that it is presumably as effective as any other now in existence in Canada; nor should it detract from the credit due to Dr. Clyde Marshall, the present Administrator of Mental Health Services and to the staff at the Nova Scotia Hospital for making such spectacular improvements during the past few years.

3. The Municipal Mental Hospitals (2) (7)

There are eight Municipal Mental Hospitals in Nova Scotia; these are located in the counties of Cape Breton, Pictou, Cumberland, Kings, Annapolis, Lunenburg and Halifax—there is also a Halifax City Mental Hospital.

The Municipal Mental Hospitals contain a total of 2,161 patients (an average of 250 each) made up mostly of seniles, schizophrenics and severely retarded mental defectives. These institutions admit a total of 350 patients a year, two-thirds of whom are transfers from the Nova Scotia Hospital, with one-third admitted directly. Since Nova Scotia is short of chronic disease hospital beds, this tempts some general practitioners to try admitting patients to the Municipal Mental Hospitals who have disabilities which are primarily physical; for this reason Dr. Marshall requires that, where possible, all patients admitted directly be seen first by a psychiatrist. The low rate of turnover in Municipal Mental

Hospitals is viewed critically by those who view these institutions as custodial rather than treatment centers; this low turnover more than balances the high turnover of the Nova Scotia Hospital at Dartmouth. Admission to the Municipal Mental Hospitals is exclusively by medical certificate—in contrast to current trends elsewhere toward voluntary admission.

The policy of establishing Municipal Mental Hospitals began in Nova Scotia in 1878 when the then superintendent of the Nova Scotia Hospital sought to relieve his overcrowding and at the same time to decentralize psychiatric care. He conceived a plan of using county homes for chronic mental patients, with only the acute patients being treated in the Nova Scotia Hospital. This pattern soon extended throughout the province, and has continued since. As far as I know, the only similar program in North America is in the State of Wisconsin.

By 1955 there were 17 county institutions containing chronic mentally disordered patients; five of these were exclusively for the mentally disordered, whereas 12 had both mentally disordered and welfare patients. It is now evident that the program as originally planned was not satisfactory; both those interested in the psychotic patients and those concerned about welfare residents have complained bitterly about the county homes. Mentally sick people received too little professional attention and little is done about their rehabilitation; moreover, clashes arose among the mixed group of mentally disordered and welfare residents, with the lack of professional supervision making things worse. By 1955 it had become obvious that the truly noble experiment of 1878 had not been properly evaluated, nor had appropriate adjustments in policy come from the experience gained. So in 1955 Dr. Clyde Marshall surveyed the situation and planned radical changes. Nine of the original 17 welfare homes were either closed or made exclusively homes for welfare patients under the Department of Welfare. Dr. Marshall drew up regulations governing the eight Municipal Mental Hospitals listed above. The Province agreed to pay half of the cost of operation of those Municipal Mental Hospitals that met the new standards outlined by the 1955 regulations.

To be approved, a Municipal Mental Hospital had to (a) be visited by a physician five days a week, (b) contain only mentally ill patients—no welfare patients, (c) have one registered nurse for every 50 patients, one member of ward staff for every six, (d) be free from overcrowding, and (e) meet the recommendations of the Fire Marshal. Moreover, these institutions were to be administered by competent boards, and to have visiting committees. So far only four of the eight hospitals have arranged to meet these standards.

I visited the King's County Mental Hospital located at Waterville. It was built in 1961, at a cost of about $8,000 per bed toward which the Federal and the Provincial Governments each paid $3,000 per bed, with the county providing the balance, This Municipal Mental Hospital serves the Bay of Fundy area. Of its 190 patients, 100 come from King's County, with the remainder from counties having no mental hospital; these counties pay the average per diem cost. In an effort to cut its cost and to improve care, one such county (Hants) has established a boarding-out program. Already at a cost of $4.50 a day, it has placed in boarding homes more than 35 per cent of the patients it had had in hospital. Perhaps Nova Scotia could board out many more of the 2,160 patients now in the Municipal Mental Hospitals; much more supervisory staff would then be required, but the results should be better, and at less cost.

Of the 190 patients in King's County Mental Hospital, 67 per cent are psychotic and 33 per cent mentally defective. Of the psychotics, about 40 per cent are brain-damaged—mostly seniles with the remainder schizophrenic; the mental defectives are all severely retarded.

The hospital operated under a local Board of Management. The hospital director has had considerable experience with psychiatric patients, but of course is not a physician. Yet he has to make most of the decisions regarding discharge of patients, although psychiatrists from the nearby Mental Health Center visit periodically. Psychiatrists from the Nova Scotia Hospital visit occasionally as it is the goal of the Department of Health to have each patient examined by a psychiatrist at least once a year. The local general practitioner visits the institution five days a week, and is on call for medical emergencies.

The King's County Mental Hospital has a ward staff of 59 for its 190 patients. The staff has set up an occupational therapy program, but most of the treatment consists of tranquilizing drugs which the Government provides free of charge to patients in hospital—although these drugs are not free to discharged patients. Commendable features of this institution include the local interest aroused through the Management Board, and the Visiting Committee, and, of course, the proximity of the patients to their homes—especially those living in King's County. The problems and possible criticisms of the institution include: (a) difficulties in keeping it unlocked, (b) the lack of professional staff, (c) the involuntary admission of all patients, (d) the separation from the area's general hospitals—despite the daily visit from the local general practitioner. How well the community accepts this institution as a health facility on a par with its general hospital is open to question—certainly some stigma persists. Other problems include the low rate of turnover, and the failure to follow up discharged patients.

One wonders whether the operation of the Municipal Mental Hospitals, and their acceptance by the public, would not be greatly improved if they were part of local general hospitals. Perhaps in some areas this could be achieved by adding to the mental hospital some beds which could be used to meet the medical, surgical, obstetrical and paediatric needs of the community. Would not the treatment program also be improved by locating the community mental health center at the district hospital, which could then combine psychiatric consultation services with physical and psychiatric in-patient care? Certainly Nova Scotia's Municipal Mental Hospitals raise some interesting questions concerning the care of chronic mental patients. Scientific evaluation of what happens in these institutions would provide much useful information on the treatment of mental illness.

4. Community Psychiatric Services (2) (4)

(a) *Out-patient Department - Victoria General Hospital*

The psychiatric out-patient department of the Victoria General Hospital comprises by far the most active community psychiatric service in Nova Scotia. Under the direction of Dr. S. Hirsch, this clinic provides the equivalent of two full-time psychiatrists and four residents. It handles an average of 300 patients each month, with only one per cent of those referred being committed to the Nova Scotia Hospital. The clinic has close liaison with the White Cross Center of the Canadian Mental Health Association.

In association with the in-patient psychiatric service of the Victoria General Hospital, the out-patient department comprises part of the University's psychiatric training facilities. The present clinic at the Victoria General Hospital evolved from a service initiated 22 years ago by Dalhousie University. In 1941, with financial support from the Rockefeller Foundation, Dr. R. O. Jones established a psychiatric service at the Dalhousie Public Health Clinic. This mental health service was the first of such clinics in the Atlantic Provinces and provided a prototype which has been useful in the subsequent development of community clinics. With the return of Dr. Frank Dunsworth to Nova Scotia in 1948, the mental health service at Dalhousie spawned the present Child Guidance Clinic.

Early in the 1950's, the Victoria General Hospital took over most of the out-patient facilities previously operated at the Dalhousie Public Health Clinic; the University continued to staff the psychiatric clinic, which became the out-patient department of the Victoria General Hospital. At first, non-medical professional staff of this out-patient clinic were supplied through the National Health Grants—later this obligation was taken over by the Nova Scotia Hospital Commission. Meanwhile, without financial help from the province, the private practitioners on the staff of the University Department of Psychiatry continued to provide psychiatric supervision for the out-patient and emergency services.

(b) *Community Mental Health Centers* (7) (8) (9) (10)

More than other Canadians, Nova Scotians literally interpret the theory that psychiatry should be a community responsibility, and so the Province now has seven Community Mental Health Centers outside of Halifax. Scattered throughout the province, these are mental health out-patient clinics, each with a psychiatrist, a psychologist and a social worker. Each center serves an area of about 2,000 square miles, with an average population of 55,000.

The first Community Mental Health Center set up in Nova Scotia under Government sponsorship opened in 1954. Previously, Dr. Chester Stewart, then Dalhousie's Professor of Social Medicine (now Dean of the Medical School) had contrived a plan for decentralizing health services by dividing the province into ten regions. Seven of these regions now have Community Mental Health Centers. These are Cape Breton, the Eastern Counties, Cobequid, Fundy, Digby-Annapolis, Western Nova Scotia and the South Shore; the Pictou and Cumberland Regions do not yet have Mental Health Centers, and the Halifax Region, although it provides a half-time child guidance clinic in co-operation with the University, does not have a regional clinic for adult psychiatry.

In planning Nova Scotia's Mental Health Centers, Dr. Clyde Marshall adhered to a policy of local administration operating on funds from National and Provincial sources (a system which has worked so well in Britain's National Health Service); he also planned for one psychiatrist for each 50,000 population (Cape Breton now has three psychiatrists and Fundy two). Dr. Marshall set up the Mental Health Centers to provide psychiatric service to patients and to organizations interested in psychiatric patients including the local medical practitioners and the welfare agencies. He planned that the centers would (*a*) provide public education on psychiatric matters, (*b*) promote the prevention of mental illness, either by early treatment or other measures, (*c*) contribute to psychiatric knowledge through research.

Urged on by the Nova Scotia Division of the Canadian Mental Health Association, the government fostered the organization of community boards to operate the Mental Health Centers. Having administrative responsibility, each of

the ten to 24 members of the local board is usually selected because he has previously demonstrated some administrative competence. To the board the government appoints members selected by the local medical association, by the local ministerial association, and by the provincial mental health authority. Besides the Administrative Board, the Act governing the Mental Health Centers provides for an advisory group including such professional people as social workers and others with relevant professional interests.

The Dominion-Provincial Mental Health Grants furnish nearly 90 per cent of the funds required to operate the mental health centers. This portion of the budget pays the salaries of the psychiatrist, psychologist, social worker, and pays for travel and office equipment. If the board wants to add additional staff, it must raise the funds locally. So that the members of staff will not be considered civil servants, the board has the responsibility of recruiting and directly paying their salary. This allows the board to stimulate recruiting by supplementing the original salary. The board must provide quarters for the center, either by erecting separate buildings, or by locating the center in the local hospital or other municipal structure.

I visited a typical Mental Health Center which is located at Wolfville and serves the 50,000 people of the Fundy Region. The present director, Dr. E. J. Cleveland, organized this center in 1954—the first provincially sponsored Community Mental Health Center to open in Nova Scotia (excepting, of course, the demonstration clinic operated by the Cornell Project at Digby). Unlike most of the centers organized later, the Fundy Center was organized in response to pressure from the local medical practitioners. This explains the presence of five doctors on the Board of Management. Participating in this Center's research program, the local University plays an active role and furnishes some of the board members. For patients who can afford to pay, the Center charges from 50¢ to $5.00 a visit—depending on the patient's means, and 10 per cent of what is collected is kept by the Center for operating purposes—the balance goes to the Provincial Government.

Of 272 referrals during the most recently reported year, 35 were psychotic, 106 neurotic, and 131 displayed character disorders. Eleven patients were certified by the Center staff to the Nova Scotia Hospital at Dartmouth; these patients were considered too disturbed to be kept as out-patients, or required some special investigation only obtainable in Halifax. In the same year, family doctors certified directly 48 other patients to the Nova Scotia Hospital from the Fundy area. Although the Center psychiatrists can admit patients to the local general hospital, they do not make a practice of this—they prefer to act as consultants in therapy to the family doctors who admit the patients, and usually are collaborating on two or three in-patients at any one time. There is no formal psychiatric service—no ward in the local general hospital, nor is any wanted; the pattern differs in some of the other mental health centers—Antigonish, for example, in the Eastern County Region, has a ten-bed psychiatric ward in its general hospital.

Treatment in the Fundy Mental Health Center is mostly eclectic; there is some electroconvulsive therapy and a lot of psychotherapy—particularly group therapy with families. The psychiatrists try to involve the 44 family physicians practising in the Fundy Region. They sometimes have the general practitioner sit in while investigation and treatment are in progress, and they always send the patient back to his family doctor. In addition to return interviews with the

Center staff, follow-up of the patients is carried out through 10 to 12 social workers employed by other agencies in the region and through six public health nurses.

Organizing community mental health services in this way has several advantages including (1) flexibility in operation, (2) enthusiastic community involvement, (3) the lack of stigma so often associated with psychiatric facilities, (4) a reduction in the number of psychotics certified to mental hospitals.

Critics raise some questions concerning the operation of the community centers. Are too many patients kept in the community who should be removed—at least for brief periods? To answer this would require a scientific study of what happens to the patients and to their families. On the other hand, some critics suggest that even fewer patients from the area require admission (in 1961, 48 were certified directly by their physicians to the Nova Scotia Hospital); to eliminate admission to NSH would require an active psychiatric ward in the Wolfville Hospital which, at the moment, the clinic psychiatrists do not want.

Some observers believe that the Community Mental Health Centers would be better located close to a local hospital which provides complete in-patient service for both the physically and the mentally ill of the area.

One other suggestion was heard concerning community mental health services in Nova Scotia: that the Government, through these community clinics, should distribute ataractic drugs free to discharged patients.

5. Services for the Mentally Retarded (11)

There are 160 mentally retarded patients in the Nova Scotia Training School at Truro, including 100 educable high-grade and 60 trainable middle-grade mental defectives. This school is operated by the Department of Welfare, but all admissions to it are approved by the Administrator of Mental Health Services. The Training School accepts no retarded patient with an IQ of less than 35—the severely retarded are admitted to the Municipal Mental Hospitals.

There are about 115 severely retarded patients in the eight Municipal Mental Hospitals—the exact number is hard to determine. The total admission of mental defectives each year in Nova Scotia is only 59.

Here, as in other provinces, the Association for Retarded Children (made up largely of interested relatives) has taken the initiative in demanding better services. In Nova Scotia, the Association for Retarded Children is asking for more money for grants to privately operated training programs which run nurseries for retarded children and prepare adults for jobs. The Association also seeks funds for the training of teachers; in Halifax it has asked that diagnostic services be set up in the Children's Hospital—rather than at the Child Guidance Clinic across the street. The Association is bitterly opposed to the practice of keeping severely retarded patients in Municipal Mental Hospitals, and asks for other types of accommodation for those with severe handicap.

The Provincial Authorities have recognized the disadvantages of having the severely mentally retarded in the Municipal Mental Hospitals, and are considering plans to develop 50-bed satellite units in suitable locations across the Province.

6. Child Psychiatry

As in other provinces, many people in Nova Scotia talk a great deal about the need for more psychiatric service for children, but very little is done about it. It is not clear whether this lack of development reflects some unidentifiable opposition to providing more child psychiatric services, or results from disagreement as to what psychiatric services should be provided for children. At the moment, the only psychiatric service restricted to children in Nova Scotia is the half-time Child Guidance Clinic in Halifax which is jointly operated by the City, the Province and the University. Nonetheless, all seven community mental health centers see a large number of children as patients—approximately 30 per cent of all referrals are under the age of 16.

7. Services in General Hospitals (12)

Including the psychiatric unit in the DVA Hospital, Halifax has four psychiatric units in general hospitals; there is also a 10-bed unit in a general hospital at Antigonish.

In 1957, a 24-bed psychiatric ward was opened in the Victoria General Hospital; this was the continuation of an in-patient psychiatric service started by Dr. R. O. Jones in 1941. Until this psychiatric unit opened in 1957, Dr. Jones treated his psychiatric patients on the medical wards. At the present time, the unit averages about 30 new admissions monthly with not more than a dozen patients a year being transferred to the Nova Scotia Hospital.

Along with the out-patient psychiatric service, the ward serves as a base for psychiatric teaching for both residents and medical students.

Other general hospital units staffed by the University as psychiatric teaching centers include the psychiatric wards in the Halifax Infirmary, in the Canadian Forces Hospital, and at the Camp Hill DVA Hospital.

Of the twelve general hospitals in Nova Scotia containing more than 100 patients, eight have psychiatric services; five other hospitals with less than 100 patients have similar programs. For the most part, these services are provided through visits by consultant psychiatrists coming from nearby community mental health centers.

Partly because Nova Scotia has developed a psychiatric program which includes a well-staffed mental hospital for active treatment (at Dartmouth) plus eight Municipal Mental Hospitals, and seven Community Mental Health Centers scattered through the Province, psychiatric units have not developed in Nova Scotia general hospitals to the same extent as in some other provinces; yet there is evidence to suggest that even this might change. The psychiatrist of the Community Mental Health Center in the Eastern Counties Region operates the ten-bed psychiatric unit at Antigonish. This pattern provides an opportunity for psychiatrists to work closely with local physicians in treating psychotics near home rather than at the distant Nova Scotia Hospital. If patients are to be treated in such units rather than in the Nova Scotia Hospital or in the Municipal Mental Hospital, both the psychiatrists and the family doctors will need more help from social service workers and public health nurses; more of these workers with psychiatric training will be needed in the community. It is hoped that one such fully staffed region will be set up capable of treating all psychotics locally; this would be a useful pilot project.

8. Private Psychiatrists

There are eight private practitioners of psychiatry in Nova Scotia—all located in Halifax. Under the vigorous leadership of Dr. R. O. Jones, private psychiatry has made, proportionately, a greater impact in Nova Scotia than in any other province. Psychiatrists in private practice have taken an active part in the debate about what the future patterns in psychiatry should be. The Maritime Medical Care Plan accepts accounts from private psychiatrists to the extent of $15.00 for an EST treatment, $15.00 for sub-coma insulin, and $3.00 daily for each patient in hospital. Those who believe that the right to do private practice improves the image of psychiatry and helps to recruit psychiatrists have suggested that care of patients in the Nova Scotia Hospital and in other provincial institutions should be financed through an insurance scheme with physicians paid a fee for service.

The efforts of Nova Scotia psychiatrists in private practice to have most psychiatric service financed on a fee-for-service basis has met with a mixed reception. Some believe that the current trend towards more state programs in medicine foretell the end of private psychiatry, as we now know it; others believe that a broader base of government financing for all medical care may remove the distinction between private and the state psychiatrists as it removes the difference between private and public patients—that, in effect, all psychiatrists will be in private practice.

9. Psychiatric Education

The Medical School at Dalhousie has a vigorous Department of Psychiatry which has made an impressive impact on undergraduate and graduate medical teaching. As part of an integrated psychiatric teaching program, residents from the Maritime Provinces spend two years within the University's Department of Psychiatry—this in addition to any time spent at the Nova Scotia Hospital. This teaching program is financed in part through contributions by all four provinces from their Dominion-Provincial Grant funds; the teachers from Halifax make regular visits to provincial psychiatric centers in each of the four provinces. Dr. Jones and his group stage frequent refresher courses for general practitioners. An evaluation of the impact of this teaching program on the work of general physicians would provide useful information.

The teaching program at Dalhousie has had an important influence on the provincial program in psychiatry, partly because many of its graduates now serve in the Community Mental Health Centers. Moreover, the psychiatric staff at Dalhousie University has participated actively in medical and psychiatric affairs, both in Nova Scotia and at the National level. This contact of psychiatrists with the local members of the medical profession has created greater interest in psychiatry among general physicians. The activities of psychiatrists with voluntary agencies has improved the public's attitude towards psychiatry in general.

10. Research

In addition to the clinical and basic research programs in psychiatry at Dalhousie University, Nova Scotia has been the site of an active research in

community psychiatry. This was carried out in the Digby—Annapolis region under the direction of Professor Alexander Leighton of Cornell University; it was financed, in part, through the Federal Health Grant funds. The projects underway at Digby are now almost completed, and there is fear that grant funds which in the past were spent for research might in the future all go for service. Already the United States spends ten times as much per capita as Canada on research and a further increase in this disparity would lead to an even greater emigration of research workers from Nova Scotia.

11. Canadian Mental Health Association (13)

The Nova Scotia branch of the Canadian Mental Health Association has had a long history, and an impressive list of contributions. Founded in 1908, it has initiated and supported many successful psychiatric developments. It helped launch a number of the community mental health centers. It promoted the building of the Nova Scotia training school at Truro, and had a hand in establishing the Department of Psychiatry at Dalhousie University. It also fostered volunteer visiting at the mental hospitals. This record shows the advantage of non-professional support in improving mental health programs.

12. Rehabilitation

Despite a general agreement that the most serious deficiency in the treatment of psychiatric disorder is the lack of rehabilitation facilities, Nova Scotia, like other provinces, does little to secure paying jobs for the mentally handicapped. There is a shortage of trained psychiatric social workers in provincial mental hospitals, and almost no follow up. There is still much to be done in giving psychiatric orientation to the public health nurses. The only sheltered workshop results from a project established in Halifax by the Junior League. Many would welcome more Federal financial support to pay the salaries of more workers to follow up discharged psychiatric patients. In the health service of the local authorities, the British have such rehabilitation programs —both for psychotics and for neurotics; up until now no Canadian province, including Nova Scotia, has done much about the rehabilitation of the mentally disordered.

13. Other Medical Services Related to Psychiatry

(a) *Family Doctors*

There are 719 practising physicians resident in Nova Scotia, making a ratio of one to 1,013 compared to one to 879 in the rest of Canada. There is an increasing interest in psychiatry among non-psychiatric physicians—especially in the younger group. I discussed psychiatric problems in practice with a physician in Halifax who was thought to hold typical views. He told me that, by and large, he and his colleagues were content with the facilities available for handling the severely psychotic, and also were themselves willing to deal with the mild emotional problems, but they were dissatisfied with the resources for the patients in between. He insisted that more general physicians should be allowed to admit and treat their own psychiatric patients on general medical wards. As a group the Nova Scotia Division of the Canadian Medical Association has

criticized the current pattern of municipal mental hospitals, and has asked for a closer integration of psychiatry with the rest of medical practice. With the trend towards more community care in psychiatry, and with drugs available to handle the more severe psychoses outside mental hospital, it appears that more general physicians should be encouraged to treat their own mentally ill patients using psychiatrists chiefly as consultants—especially with emergencies.

(b) *General Hospitals*

The 47 general hospitals in Nova Scotia have a total of 3,563 active beds, making a ratio of about five beds per 1,000. The Canadian Medical Association, Nova Scotia Division, has recommended a ratio of seven active beds per 1,000, plus some chronic beds. At the present time there are a few beds listed for convalescent care, and less than 1,000 chronic hospital beds for physical disease in the entire Province.

Since brain-damaged old people occupy at least a third of Nova Scotia's psychiatric beds, perhaps Nova Scotia needs more active geriatric services in general hospitals. For old people with severe physical handicaps, geriatric services could relieve some of the pressure for their admission to mental hospital on the doubtful grounds of being mildly mentally confused.

(c) *Nursing*

There are about 2,600 registered nurses in active service in Nova Scotia; most of these have not had even brief psychiatric orientation or training. With the trend in the Province towards the integration of psychiatric service into general medicine, all student nurses should have more psychiatric instruction. A new nurses' residence at the Nova Scotia Hospital will make it possible for all nursing students to have affiliation in psychiatry.

(d) *Public Health*

The Province has eight public health units, plus the Department of Health in the City of Halifax. The Director of Mental Health Services has set up a program of psychiatric orientation for public health nurses, which should help overcome some of the deficiencies in rehabilitation and improve community psychiatric care. The use of public health nurses to follow up discharged mental patients should be extended considerably if the boarding-out program (as in Hants) is to expand.

14. Conclusion

A survey of trends in psychiatric care in Nova Scotia reveals many interesting and commendable features. The intensity of the debates on what should be done to improve services shows the depth of interest; the tensions between those who share different viewpoints have led to many constructive developments. The original and varied programs in Nova Scotia psychiatry offer an admirable opportunity to compare the relative effectiveness of different ways of providing psychiatric services; surely here is an ideal site for operational research.

The vigor of the private practitioners of psychiatry, and their feeling of personal responsibility towards improving the Province's psychiatric services present an opportunity to examine the possible contribution of insurance agencies in providing psychiatric care.

The community mental health centers are certainly Canada's most thoughtful attempt to create broad community psychiatric services; they furnish a particularly interesting example of local administration of a program paid for by funds from a central government.

The boarding-out program recently started in Hants provides another way of looking after mental patients.

Less commendable patterns observed in Nova Scotia include the persisting separation between psychiatric services and the rest of medicine. Few would claim that the mentally ill in Nova Scotia (or, for that matter, in any other province) are treated like other sick persons. Most doctors do not think of the Municipal Mental Hospitals as part of Nova Scotia's treatment service. Although most general hospitals have consultation services from the Community Mental Health Centers, they do not admit and treat psychotic patients. Finally, one must regret the failure to use the variety of programs developed in Nova Scotia as pilot projects for operational research.

I think that a future study of trends in Nova Scotia will show the Province continuing to break new ground, and trying out different methods. It is likely that private psychiatry and government psychiatry will be closer together, and join hands in developing new community programs. It seems certain that, in the future, all of the present programs will be reviewed with a critical and scientific eye so that the rest of Canada can learn much from a province which, in its characteristic Celtic fashion, does things differently.

REFERENCES

(1) *Government of Nova Scotia,* brief presented to the Royal Commission on Health Services, October 1961.
(2) Marshall, Clyde, M.D., Nova Scotia's Expanding Mental Health Program, *The Nova Scotia Medical Bulletin,* July 1962 issue.
(3) Report of the Department of Public Health, Nova Scotia, December 31, 1960.
(4) Marshall, Clyde, M.D., The Nova Scotia Mental Health Plan, *Canada's Mental Health,* May 1962.
(5) Marshall, Clyde, M.D., Treatment Close to Home, *Mental Hospitals,* June 1962.
(6) Annual Report of the Nova Scotia Hospital, December 31, 1960.
(7) *Standards for Municipal Mental Hospitals*—Statement from Department of Health, Nova Scotia, 1955.
(8) Questions and Answers about the Fundy Mental Health Centre, Wolfville, Nova Scotia.
(9) Cleveland, E. J., M.D., and Townsend, F. R., M.D., Progress Report of a Clinic Located at Wolfville; unpublished.
(10) The Fundy Mental Health Centre Seventh Annual Report, December 31, 1961.
(11) *The Nova Scotia Association for Retarded Children on Current Problems in the Care, Training and Education of Retarded Persons,* brief presented to the Premier of Nova Scotia, March 1961.
(12) *The Medical Society of Nova Scotia,* brief presented to the Royal Commission on Health Services, October 1961.
(13) *The Canadian Mental Health Association,* Nova Scotia Division, brief presented to the Royal Commission on Health Services, October 1961.

CHAPTER 4

TRENDS IN PSYCHIATRIC CARE IN PRINCE EDWARD ISLAND

1. Introduction

In discussing trends in psychiatric care in Prince Edward Island, I shall describe the mental hospital services, the community psychiatric services, and the place of psychiatry in the provincial health organization. Then I shall examine the relationship of psychiatry in Prince Edward Island to such other health services as are provided by the general hospitals, by the medical practitioners, and by salaried public health workers; such special subjects as services for emotionally disturbed children, the aged, rehabilitation, problems in private psychiatric practice, research, and public education will also be considered.

2. Psychiatric Services—General

(a) *Mental Hospitals* (1) (2) (3)

The Riverside and the Hillsborough General Hospital provide the only officially recognized in-patient service for psychotics, neurotics, the severely retarded, and for alcoholics, although, as in all other provinces, many mentally disordered people are unofficially treated in the general hospitals. Erected in a beautifully wooded area on Hillsborough Bay near the City of Charlottetown, the original institution was called Falconwood. The name Falconwood acquired the stigma that has been the lot of all mental hospitals, and so, to improve its public image, it was recently renamed Riverside. One of the newly constructed buildings nearby was somewhat inappropriately called the Hillsborough General Hospital in an unsuccessful effort to qualify for Federal hospitalization funds.

Most of the 319 patients at the Riverside and at the Hillsborough General Hospitals are psychotic; there are, however, many adult mental defectives and several subnormal children, most of whom were admitted in 1961 when the Government transferred a chronic institution, known as the Provincial Infirmary, from the administration of the Department of Health to the Department of Welfare; now it is only for the aged so the retarded had to go to Riverside.

Prince Edward Island has 294 patients in mental hospital per 100,000 population compared to a rate of 372 for Canada as a whole. This is low because of the bookkeeping change which transferred the aged at the Infirmary from psychiatric to social welfare administration—not primarily the result of a fall in mental hospital population; the decrease in the number of mental patients in

Prince Edward Island from 461 in 1959 to 303 in 1960 was mostly on paper, although, thanks chiefly to setting up a foster home program, there was a decrease of about 50 patients in the population at Riverside.

Less than 25 per cent of the 319 mental hospital patients are acutely sick—the remaining 240 are made up of long-stay schizophrenics, the brain-damaged and mentally retarded.

Prince Edward Island's admission rate of 1,359 patients per 1,000 patient-population compares with the Canadian rate of 632 and gives Prince Edward Island Canada's highest admission rate per 1,000 in-patients. Besides being influenced by the lower patient-population, the higher admission rate reflects the improving public image of the mental hospital in Prince Edward Island and the proximity of the hospital to most of the Island's residents. In addition to voluntary admission and admission on two doctors' certificates, the hospital must accept patients on warrants from the Attorney General, or magistrate, or judge. The patients admitted on warrant must be examined within 48 hours of admission by two local doctors to determine whether they require certification.

The superintendent has the power to refuse admission to any patient for whom he has no room or whom he considers otherwise unsuitable. Nonetheless, in such a small province, superintendents are more vulnerable to outside pressures for admission; moreover, the lack of community resources for care for temporarily disturbed people further increases the pressure on the hospital.

Alcoholism presents special problems in admission. With alcoholic disorders making up more than 20 per cent of the total admissions to Riverside (compared to a rate of less than 7 per cent for mental hospitals in the rest of Canada), Prince Edward Island has much the highest admission rate for alcoholism in the country. Factors contributing to this high admission rate for alcoholics include (a) the gradual lessening of the stigma attached to Riverside, (b) the refusal of general hospitals to admit alcoholics, (c) the general belief that Prince Edward Island jails are deplorable, (d) the lack of facilities in the community for dealing with acute alcoholism. At present, only the general practitioners and Alcoholics Anonymous assist the Riverside Hospital in dealing with the problem; in turn, therapy for alcoholics at the Riverside includes little more than arrangements for drying out.

Although the proximity of the mental hospital to the patients' homes aids in discharge, as does the Government's policy of providing ataractic drugs for discharged patients, the lack of follow-up services impedes early discharge and successful rehabilitation. The boarding-out program has not been fully exploited. A shortage of staff hampers the follow-up activity of the mental health clinics. Yet, the hospital reports a noteworthy achievement in discharge over a five-year period, adding to its chronic list an average of less than one female schizophrenic patient each year.

With a total of 164 members of staff in its mental hospital, Prince Edward Island has the second highest rate of staff per patient in Canada (654 per 1,000 compared to 418 for the Canadian average); this is partly because placing the confused old people under Social Welfare left Riverside with fewer patients —more of whom were acutely sick requiring more staff per patient.

Riverside has had its troubles maintaining an adequate medical staff; during the past three years the medical staff has come and gone at an alarming rate.

This resulted partly from the enthusiasm and impatience of young psychiatrists who wanted to see things improved quickly. (There is evidence that the tactics of the "Young Turks" made a useful impact on the authorities, and will result in long-term benefits.) At the time of my visit in October 1962, the hospital had one certified and two uncertified psychiatrists; it also had a list of 23 part-time consultants including, besides almost all of the specialists in Charlottetown, most of the psychiatrists on the staff of Dalhousie University.

The 164 members of staff at Riverside and Hillsborough include 77 ward staff who, in turn, include 14 registered nurses and a number of attendants and ward aides. There is a course for nursing assistants and undergraduate nursing students from the three schools of nursing in the province; for some reason, not clear to me, the affiliation program appeared to be in jeopardy. The hospital has five social workers who also work with the mental health clinics.

Apart from the constantly changing medical staff, one gets the impression of a stable interested hospital staff who keep the hospital in good physical condition and provide the patients with good care; the occupational therapy program is particularly vigorous. More adequate medical staffing would permit more special psychiatric treatment, make the ward more open, and improve the rehabilitation services.

(b) *Services for the Mentally Retarded* (5)

Il one accepts the realistic (and conservative) estimate of 2 per cent of the population as retarded, then Prince Edward Island would have 2,000 mental defectives of all ages. Using the Classification of E. O. Lewis, this would make 1,500 in the higher grade group, 400 in the middle level, and 100 severely retarded. Riverside now has the most severely retarded children, and a number of retarded adults.

The highlight of the care of the mentally retarded in Prince Edward Island is the Sherwood Hospital School opened in 1962. Situated quite near Riverside, this institution has 21 beds for educable and trainable retarded children. It also houses the day-training program for retarded children from Charlottetown who come to the center each day by bus. There are also day-training schools at Tignish, Alberton, O'Leary, Summerside, Montague and Souris.

Prince Edward Island's program for looking after its mentally retarded has inproved greatly during the past few years, thanks in no small measure to the efforts of Dr. Malcolm Beck, who, along with some officials of the Canadian Association for Retarded Children, had much to do with establishing the Sherwood Hospital School. As Director of Child Guidance Services, and Chairman of the Advisory Committee of the Prince Edward Island Division of the Canadian Mental Health Association, he carefully studied the Island's needs for its mentally retarded; his 1959 report "A Program for the Care of Mentally Retarded Children" created much interest. Adopting, as a guiding principle, the desirability of community care, it also recommended better diagnostic services, better services for institutional care, home visiting, and a redrafting of the laws dealing with mental deficiency.

The Prince Edward Island Association for Retarded Children supported Dr. Beck's recommendation and repeatedly decried the present pattern of housing severely retarded with the psychotics in Riverside. The same group has sponsored day care services at Charlottetown and at Montague.

After examining Prince Edward Island's present program for the retarded, and the needs for the future, certain likely trends become apparent:

(i) Pressure for domiciliary facilities outside of Riverside will continue; some suggest this might be met by establishing 50-bed units for lower grade patients at Summerside and Charlottetown—perhaps near the general hospitals.

(ii) All agree on the need for home visitors to help parents who keep their retarded children; authorities disagree, however, on whether to have workers full-time with the mentally retarded, or to train public health nurses and social workers to do this home counselling along with their other duties. If the public health nurses could develop the skill and interest necessary for successful counselling of parents of mental defectives, this would avoid duplication of services, and increase the number of persons in the community interested in the mentally retarded. Some Island authorities have doubts about using the public health nurses in this way so pilot projects should be set up to give more accurate answers.

3. Community Services (3)

The present Director of Mental Health Clinics, Dr. Malcolm Beck, is also the Director of Child Guidance Services; for these duties he is responsible to the Director of the Mental Health Division. Charlottetown has a full-time mental health clinic which combines adult services (provided by a psychiatrist from the Riverside Hospital) with its child guidance clinic; the staff of this unit also holds weekly clinics at Summerside. So the staff of the adult clinic includes part-time psychiatrists at Summerside and Charlottetown, plus psychologists and social workers. This clinic provides consultation services for physicians together with some out-patient treatment; it distributes the ataractic drugs provided free by the Government for discharged patients.

Problems facing the clinic for adults include the growing waiting list, and a lack of consultation services in the extreme eastern and western parts of the Province. With its population of 100,000 the Island needs at least two full-time clinics, which would be best located at Charlottetown and Summerside; these could provide visiting services to places like O'Leary, Montague, and Souris.

4. Administrative Organization of Psychiatric Services

The Department of Health looks after the organized health services for the 103,000 citizens of Prince Edward Island; the responsibility rests with the Minister of Public Health and his Deputy. The Deputy Minister of Health is also the Chief Health Officer for the Province, and Executive Director of the Hospital Services Plan. The Deputy Minister, in turn, delegates responsibility for the Division of Mental Health to a Director who is always a psychiatrist. The Division of Mental Health is divided into clinic and hospital services.

By an Order in Council in May 1961, the Government set up a Board of Governors to act as a policy body in the administration of the mental health program. Seven leading citizens were appointed by the Executive Council to serve on the Board without pay. The Minister of Health acts as the Board Chairman.

The Board meets monthly to advise the Government on the best use of its resources in the mental health field. The apparent advantage of the Board is that its members, not being civil servants, need have no hesitation to express disagreement with policy, or disapproval of the services being provided.

Eight hundred and thirty-three thousand dollars of the $3,000,000 Provincial Budget is used to operate the Mental Hospital. In addition, there is a $74,185 Dominion-Provincial Mental Health Grant (plus nearly $30,000 from other National Health Grants) used to supplement the Province's share of mental health costs. The grants support the full cost of the mental health clinic, and of the child guidance service, and pay salaries for the medical staff at Riverside—except for the Director. These grants also finance the occupational therapy unit at Riverside.

The National Health Grants also supply funds to finance the regular visits of consultants in psychiatry from Dalhousie University, and contribute Prince Edward Island's share of the cost of the post-graduate teaching program in psychiatry at Halifax.

It is obvious that Prince Edward Island has to struggle to raise the funds needed to establish a highly efficient psychiatric service. More than some of the larger provinces, Prince Edward Island will need a subsidy from the Federal Government if it is to modernize its psychiatric program further.

5. The Relationship of Psychiatric Services to Other Health Services in the Province

(a) *General Hospitals*

There are eight general hospitals in the Province, three having about 100 beds and five smaller hospitals with between 12 and 50 beds.

The three larger hospitals are at Charlottetown (with the Charlottetown Hospital, and the Prince Edward Island Hospital) and at Summerside (the Prince County Hospital). The smaller hospitals include the Kings County at Montague, the Community Hospital at O'Leary, the Souris Hospital at Souris, the Western Hospital at Alberton, and the Stewart Memorial Health Center at Tyne Valley. These hospitals have a combined total of 637 acute beds, providing more than six acute beds per 1,000 population which is definitely better than the Canadian average. Differences of opinion exist in Prince Edward Island as to the adequacy of this ratio to meet the needs of the acute sick. Part of the disagreement hinges on the even sharper differences about the number and location of chronic beds needed. At present, there are more than 100 chronic beds—with plans for more.

Obviously the number and situation of general hospital beds, and the policies governing their use, affect mental health care. Officially there is complete separation between psychiatric and general hospital services. There are no psychiatric units, and hence no place where general physicians and psychiatrists can work closely together in the in-patient treatment of patients. There is one exception to this—general practitioners can admit and treat psychiatric patients in general hospital wards provided this has the approval of a psychiatrist. This is a most interesting trend, and could be a forerunner of much closer co-operation to come between psychiatrists and other physicians.

Meanwhile there is much support for the recommendation that there be psychiatric units in at least one (possibly both) of the Charlottetown general

hospitals, and a psychiatric unit in the general hospital at Summerside. These wards could be tied in with proposed full-time clinic services in both of these centers. This would help eliminate the segregation of the mentally ill which now exists in the Province. Another possibility would be to develop other non-psychiatric medical services at Riverside to serve the Charlottetown population; such should improve the image of the Riverside Hospital and of psychiatric care in the Province.

(b) *Medical Practice* (4)

There are 90 active physicians in Prince Edward Island, making a total of one physician for 1,140 population—compared to the Canadian average of one to 890. Thirteen of these doctors are on salary (including three psychiatrists), 33 are certified as specialists (including one in psychiatry) and 44 physicians are in general practice.

With a potential list of 77 general practitioners and specialists referring to one private and three government psychiatrists (who also have other duties besides acting as consultants), the psychiatrists cannot keep up with demands. Whether or not interested in psychiatry, all of the 77 non-psychiatric physicians have some patients who are anxious, confused or depressed; some of these patients they must treat, and for others they need help from psychiatrists.

With an increasing tendency for physicians to seek consultation support, it is apparent that more consultants are needed. Whether these are private psychiatrists or full-time consultants in government service, or a combination of both, should depend on how other consultation services are provided. Certainly, located at either Charlottetown or Summerside, there should be five or six psychiatrists available to make consultation visits to centers like O'Leary, Alberton, Montague and Souris.

(c) *Nurses* (2)

As elsewhere, the nurses of Prince Edward Island come in contact with the mentally disordered, and must be considered in a survey of service trends in mental health. There are 185 R.N.'s with a total of 50 graduates each year from three schools of nursing. There is a somewhat experimental policy of sending students to affiliate for twelve weeks at Riverside; this must be continued if the nurses are to play a useful role in treating the mentally disordered.

(d) *Public Health* (1)

The Assistant Deputy Minister of Health is responsible for most of the divisions in the Department—other than mental health. Some of these, including Public Health Nursing, Rehabilitation and Child and Maternal Welfare are of particular interest to those planning mental health services. In a former sanatorium building, the Rehabilitation Division operates 30 beds which are used mostly for the rehabilitation of patients with medical problems arising from poliomyelitis, cerebrovascular accidents, etc. This has the beginnings of an active program of rehabilitation for the medically handicapped, and ties in with the Federally supported, Provincial rehabilitation program of which the Deputy Minister of Social Welfare is the co-ordinator. Yet I found no evidence that those

responsible for this program had responsibility for the rehabilitation of the mentally disordered as well. Certainly high-grade mental defectives, and many chronic schizophrenic patients need the sort of job evaluation, retraining, and job placement which is being developed for patients with other medical problems. There should be a sheltered workshop in Charlottetown to which the mentally disordered could go, and possibly one in Summerside also.

The Assistant Deputy Minister also directs the fifteen public health nurses. Thirteen of these do field work—none of which is in the realm of treatment. The public health nurses demonstrate their interest in mental health by making orientation visits to Riverside, and by keeping up some contacts with that hospital; they also provide some help to the Day Center for the retarded at Montague.

One wonders why Prince Edward Island does not follow the pattern developed elsewhere of using public health nurses to follow up discharged psychiatric patients; perhaps too they should do home visiting of families with a mentally retarded child (all this in close co-operation with the family doctors). If public health nurses are to assume these additional duties, many more will be needed, and there will have to be more Federal support, both for salaries and for health training. How successfully the public health nurses could meet this added responsibility could only be determined by trial. They would need much support and supervision from psychiatrists and social workers.

6. Special Problems

(a) *Services for Emotionally Disturbed Children* (3)

Under the direction of Dr. Beck, the Child Guidance Services hold daily clinics in Charlottetown and weekly clinics in Summerside. There are also some psychiatric services provided for children at Alberton, Montague and Souris. In addition to a child psychiatrist, a psychologist and a social worker, the clinic has three liaison teachers, the first of whom was appointed in 1954. These are teachers trained in child psychology, who act throughout the Province as consultants to school teachers. They visit classrooms, see some problem pupils, and talk to teachers and parents. This program has been well accepted in Prince Edward Island. In 1960, the Mental Health Clinic also acquired a speech therapist.

A visitor gains the impression that morale is high in Prince Edward Island among those developing psychiatric services for children, and that progress to date is remarkable. Yet there is a growing waiting list of patients, and a need for local services in such places as O'Leary in the west and Montague in the east.

There are no suitable in-patient services for emotionally disturbed children, and for this the Island needs at least fifteen beds.

(b) *The Aged* (1)

Twenty-five per cent of the 315 patients at Riverside are over 65 years of age. Many of these 75 patients are only slightly brain-damaged, and do not require 24-hour nursing and medical care. As mentioned elsewhere, the residential services for old people in Prince Edward Island are comparatively good. There is a total of 445 beds in homes for the aged (Beechgrove—164, Provincial Home for the Aged—135, Borden—18, Home for the Aged—128) giving Prince Edward Island the highest ratio of beds for this type of care of any province in

Canada. This helps to compensate for the slightly lower number of mental hospital beds.

Probably more old patients could go home from the mental hospital, and even from the homes for the aged, if the Province had a larger cadre of visiting nurses, as well as other staff trained to help in the home care of the mentally ill. This would be better than keeping many of these patients in institution, but would certainly require more trained field staff.

Those in charge of the hospital services plan in Prince Edward Island permit doctors to treat many patients with chronic disease in acute general hospitals. Brain-damaged old people (many of whom are also physically sick) would do better in general hospitals than in Riverside. Treating more of the confused old people in general hospital could lead (*a*) to integrating psychiatry with medicine, (*b*) to better diagnostic and treatment services in geriatrics, (c) to closer co-operation between psychiatrists and those interested in the physical diseases of the old. Then confused old people would be treated in general hospitals rather than in segregated units like Riverside. If it worked satisfactorily, such a plan would be better for the patient, better for the psychiatrist, and better for the family physician. There is need for a pilot project in treating such old people in a general hospital—this could well be tried in Prince Edward Island.

(c) *Private Psychiatry*

There is but one private psychiatrist in Prince Edward Island, and he is located in Charlottetown. Psychiatrists who work in the mental hospital and in the mental health clinics are excluded from seeing private cases.

One wonders whether it is wise to maintain the practice of having most of the psychiatric consultations on a different basis from consultations of other specialists. It has been suggested that the answer might be for the Government to pay an initial subsidy to consultant psychiatrists and to permit private practice rights in addition to this. This would enable the psychiatrists to make a living in a manner similar (although not identical) to the practice of other specialists.

(d) *Research*

As one would expect in a small province, little psychiatric research is done in Prince Edward Island. Most research contributions come from individuals working on problems which especially interest them; Dr. Brian O'Brien has recently reported his work on such a problem—the effect of LSD in the treatment of alcoholics.

Yet an active research program would contribute to better psychiatric care in Prince Edward Island by improving the work of the clinicians in psychiatry, and by creating a professional climate attractive to potential recruits; the big hindrance is the lack of research personnel, and the lack of funds. Perhaps, too, some of those responsible for mental health in Prince Edward Island need some convincing about the beneficial effects of research.

Psychiatry in Prince Edward Island would particularly benefit from one type of scientific study—operational research; furthermore, Prince Edward Island could make a useful contribution in this field. Many questions concerning the management of the mentally disordered can only be answered in an action situation; I have referred to some of these questions already. These include (*a*) whether to treat the mentally ill in isolated mental hospitals or in wards of

general hospitals; (*b*) to what extent should the family doctor participate in the treatment of confused, depressed and anxious people, and how should he be prepared for this; (*c*) should those who follow up discharged patients in the community be specialized workers trained in psychiatry, or should follow-up be included in the duties of staff already in the community such as public health nurses and social workers.

To answer these questions, Canadian psychiatry needs a series of controlled pilot projects. Although, on its own, the Government of Prince Edward Island could not afford to set up many such projects, yet in many ways Prince Edward Island would be an ideal site in which to carry out such operational research. The advantages of using Prince Edward Island for such research include (*a*) its mixed rural and urban population, (*b*) the size of the population—100,000, (*c*) the geographic isolation from other populations—hence stability, (*d*) facility in tracing ancestry.

For the above reasons, many think that Prince Edward Island would be the ideal site for a large research program financed with Federal and other outside funds. The university centers in Canada could contribute staff and ideas—by plane Dalhousie University is less than an hour away. Such a program would need the enthusiastic support and co-operation of the authorities in Prince Edward Island, as well as of the Federal Government, and of Dalhousie University. Some years ago, the Scientific Planning Committee of the Canadian Mental Health Association noted the advantage inherent in Prince Edward Island for carrying out such research. At that time neither the Provincial authorities nor the Federal Government were in a position to proceed with the proposal; perhaps the situation has since changed and this research could now be set up. It would bring dividends to all of Canada but above all to the residents of Prince Edward Island.

(e) *Voluntary Associations* (5) (6)

Most public education in psychiatry in Prince Edward Island is carried on by the Association for Retarded Children, and by the Provincial Division of the Canadian Mental Health Association. As mentioned previously, the Prince Edward Island Association for Retarded Children has developed day centers for children; it also has protested the practice of admitting mental defectives to Riverside.

The Prince Edward Island Division of the Canadian Mental Health Association was founded in 1959 with the object of promoting research, public education, and recruitment of hospital visitors. It has become active in relaying to the Government the views of citizens on mental health matters.

7. Conclusion

A survey of psychiatry in Prince Edward Island reveals the following trends:

(i) Use of a Board of Governors to bring lay participation into the administration of psychiatric services.

(ii) The use of the mental hospital in the treatment of large numbers of alcoholics.

(iii) A government program to provide free drugs for discharged patients.

(iv) Education of medical staff through regularly scheduled visits of certified psychiatrists from a university teaching department.
(v) The creating of a center for retarded children which combines in-patients with day-patients.
(vi) The practice of general practitioners treating psychiatric patients in the wards of general hospitals with the approval and support of psychiatrists.
(vii) Treating in general hospital the chronic sick who require nursing and medical care.
(viii) The successful employment of liaison teachers in the public school systems.
(ix) The provision, through homes for the aged, of a large number of residential beds for old people.

The survey also shows that some trends developing elsewhere are not found in Prince Edward Island at this time. These include:

(i) Psychiatric units in general hospitals.
(ii) Integrating psychiatry with the rest of medicine by using the mental hospitals to treat physically ill patients from the area.
(iii) Close integration of psychiatric services with family doctors and with public health nurses.

REFERENCES

(1) Annual Report of the Department of Health, Prince Edward Island, 1960.
(2) Interim Report of the Department of Health of the Province of Prince Edward Island, 1961.
(3) Survey of Mental Health Needs on Prince Edward Island by the Prince Edward Island Division of the Canadian Mental Health Association, March 1961.
(4) *Medical Society of Prince Edward Island, Canadian Medical Association, Prince Edward Island Division,* brief presented to the Royal Commission on Health Services, October 14, 1961.
(5) Beck, M.N., M.D., Report to the Minister of Health, Prince Edward Island, on A Suggested Program for the Care of Mentally Retarded Children on Prince Edward Island, July 1959.
(6) *Canadian Mental Health Association, Prince Edward Island Division,* brief presented to the Royal Commission on Health Services, October 16, 1961.
(7) *Prince Edward Island Association for Retarded Children,* brief presented to the Royal Commission on Health Services, October 1961.

CHAPTER 5

TRENDS IN PSYCHIATRIC CARE IN NEW BRUNSWICK

1. Introduction (1) (2)

At the end of World War II, the mental hospital at Lancaster, New Brunswick, was the victim of a violent newspaper attack in which the attackers accused the hospital authorities of abusing and neglecting their patients. Charges of this sort have often been hurled against Canadian mental hospitals, for during the past hundred years the North American public has frequently used assaults on hospital staff to relieve its own guilt over its own bad treatment of the mentally ill; aside from giving the newspaper readers a feeling of righteous wrath, the exposé accomplished little.

In 1946, like all mental hospitals the Provincial Hospital at Lancaster suffered in comparison with contemporary general hospitals, but was neither better nor worse than most other mental hospitals in Canada. Like other Canadian hospitals, New Brunswick mental hospitals have improved during the past 20 years, but not enough to be considered first-class therapeutic centers. In the struggle to provide better care for the mentally ill, the Director of Mental Health Services, Dr. R. R. Prosser, has encountered not only the obstacles faced by all other provincial directors, but, also, one or two peculiar to New Brunswick. As elsewhere, the public has been indifferent or hostile to the problem of mental illness, and quite content to have the mentally ill cared for apart from the physically sick. Progress in New Brunswick has been more difficult because of the limitations of the Province's financial resources, and because of the need to develop services for both English-speaking and French-speaking residents.

The distribution of the population, and the topographical character of the Province has also made things more difficult. Although the 600,000 inhabitants (the third smallest provincial population in Canada) occupy the third smallest area of any province (27,000 square miles), unlike the situation in Nova Scotia, the population of New Brunswick is distributed in a way which makes communication awkward. There is one concentration along the Bay of Fundy, which projects up to Fredericton. A second settled area extends further up the St. John River to the Quebec border, with a third along the Bay of Chaleur, and a fourth along the Cumberland Strait. From this, it becomes obvious that patients would experience difficulty going to centrally placed institutions for treatment and, at the same time, around the periphery of the Province, it is hard to find population clusters big enough to establish satisfactory decentralized service units.

2. Mental Hospitals (1) (2)

As in other provinces, New Brunswick's mental hospitals constitute the focal points of its psychiatric service. The Provincial Hospital at Lancaster (adjacent to Saint John) has 1,350 patients, and the Provincial Hospital at Campbellton has about 600, making a total of 1,950. This gives New Brunswick 312 patients per 100,000 population compared to 372 for the Canadian average.

According to acceptable floor space standards, New Brunswick's mental hospitals are overcrowded by at least 30 per cent. In addition to acutely sick psychotics, these institutions contain 60 mentally retarded children, and an undetermined number of mentally retarded adults; there are also patients incarcerated as criminally insane, alcoholics, and more than 600 patients over 65—many of whom could more suitably be cared for in homes for the aged. As in other provinces, these mental hospitals carry the stigma that the public has long since attached to what it considers institutions for the insane. As a result, various pressure groups strive to promote alternative facilities for the particular type of patients in which they have a special interest; thus there is much agitation to have the mental defectives, the alcoholics, and the seniles, cared for elsewhere.

The superintendents of the mental hospitals are responsible to Dr. Prosser —the Director of Mental Health Services—and he to the Deputy Minister of Health. There is a hospital budget of $3,200,000 which, in 1959, worked out to $3.91 per patient per day at Lancaster, and $5.26 at Campbellton, with an average of $4.51 per patient compared to the Canadian average of $5.31. Funds to provide the eight psychiatric social workers in the two institutions, as well as the psychologists in the hospitals, come from the National Health Grants. These grants have also been used for training staff, and during a twelve-year period, have made possible training for 19 psychiatrists for service in New Brunswick (unfortunately, many of those trained have since gone to other areas in search of higher incomes).

In 1960, the Government of New Brunswick was still able to collect $300,000 from relatives of mental patients, and $140,000 for mental hospital care from municipalities. Both the Government of the Province, and the Executive of the Canadian Mental Health Association are vigorously asking the Federal Government to include the mental hospitals under the National Hospital Care Insurance Act; this could add $1,500,000 in Federal funds to the Provincial Treasury, but if no strings were attached, would not necessarily result in a comparable improvement in the care of the mentally ill of the Province.

Where will psychotic patients be treated in future in New Brunswick? As far as I was able to find out, there has been no publicly annunciated plan, but Dr. Prosser favors establishing psychiatric units in several of the ten general hospitals that now have more than 100 beds. He would grant subsidies, and private practice rights to psychiatrists working in these units. From this arises the question as to the future of the mental hospitals if up to a total of ten acute services were developed in general hospitals. Would the mental hospitals then become repositories for low-grade mental defectives, homeless seniles, and severely handicapped schizophrenics, or would local community services be developed (along with chronic wings attached to general hospitals) so that the present mental hospital buildings might be used for some other purpose? Obviously, neither the New Brunswick authorities nor anyone else can answer these questions at the present time. Dr. Prosser would first need financial assistance and support in setting up pilot projects, and some help in evaluation of these. Nonetheless, a trial of his plan would give much useful information and

might point the way to a better integration of psychiatry with other medical care.

3. Community Services (1)

New Brunswick has five full-time mental health clinics, which are located at Edmundston, Moncton, Fredericton, and two at Saint John; one of the Saint John clinics is devoted solely to children with emotional disorders, as well as retarded children. Each clinic has the traditional staff of psychiatrists, social workers and psychologists. The psychiatrists generally work on a part-time basis (25 hours a week) and do private practice as well. The one or two social workers are usually overwhelmed by the extent of the service demands within the clinic, and so are able to make but limited community contacts outside. The psychologists assume considerable responsibility and, to a limited extent, participate in therapy.

Funds for the four clinics are provided through the National Health Grants. The clinics provide consultative and therapeutic service on an out-patient basis—there is no day care program.

The clinics make possible a fair start towards providing consultation services to all practising physicians, and to the social agencies in the Province; unfortunately the four clinics above cannot supply enough consultation service (let alone therapy) for a population of 600,000 people. At least four times as many professional workers would be needed to care for a population of this size—and one so scattered. Pertinent questions include the advisability of having such clinic services at each of the ten general hospitals (of more than 100 patients) and having each clinic attached to the in-patient services proposed by Dr. Prosser. Further questions include the possibility of closer working arrangements between the clinic staff on the one hand, and general practitioners, public health nurses and medical health officers on the other. This could be the first step towards establishing decentralized mental health services in place of admitting patients to the large isolated mental hospitals.

4. Related Medical Services

(a) *General Hospitals*

There are ten general hospitals in the Province that have more than 100 beds. These are located at Moncton (2), Saint John (2), Fredericton, Newcastle-Chatham, Bathurst, Campbellton, Edmundston, and Woodstock. Together with the smaller hospitals, they provide New Brunswick with a total of 3,275 beds or an average of about 5.2 beds per 1,000 population. Although having about the Canadian average in acute beds, the situation has been made much worse by the fact that New Brunswick has no convalescent hospital beds, and no chronic hospitals (apart from mental and tuberculosis). Many aged and infirm people not needing hospital care—but having no home to go to—live in New Brunswick's Homes for the Aged, which have accommodation for about 1,000. Although obviously many of the patients in the Homes for the Aged are mentally confused, these homes do not encourage the transfer of suitable patients to them from the two mental hospitals. The Homes for the Aged are under the direct or indirect supervision of the Department of Social Welfare. Organizations constructing such homes receive a Government Grant of $1,000 a bed. It is estimated that present demands would warrant adding another 500 beds to the total already in these hostels, making a total of 2.5 beds per 1,000, which is a little more than the

Canadian average. If the New Brunswick Government was to transfer, from its mental hospitals, all old people suitable for care in Homes for the Aged, an even greater number of these hostel beds would be needed. There seems little point in caring for any confused old people in mental hospitals who could be just as adequately looked after nearer home in local hostels.

(b) *Psychiatric Units in General Hospitals* (2)

New Brunswick has two psychiatric units in general hospitals—one with 20 beds in the Moncton General Hospital, and a second of the same size in the Saint John General Hospital; psychiatrists in private practice are allowed to admit and treat their own patients in these units. Whereas a few psychotics are treated in the two psychiatric wards, who otherwise would have had to go to mental hospital, it is obvious that these 40 beds can make but little impact on the 2,000 beds in the two large institutions. Nonetheless, they could establish a useful prototype for prospective psychiatric units in at least eight other general hospitals throughout the Province.

The question is how many acute beds would be needed in general hospitals to treat all of the mentally sick for a population of 600,000. Experience elsewhere (Manchester Hospital Region) has suggested a figure of from .5 to .7 beds per 1,000, which would mean between 300 and 400 acute beds in the Province or, in other words, ten 35-bed units in New Brunswick's general hospitals. This would not care for the Province's 150-200 severely retarded persons, and for an equal number of grossly handicapped psychotics made up mostly of brain-damaged seniles and some schizophrenics. Unless the 300-400 severely ill long-stay patients were still to be kept in isolated mental hospitals, it would be necessary to have chronic bed units attached to each of the ten larger general hospitals. This would mean 40-bed units for each hospital. It would have the advantage of keeping these really very sick people in close contact with the best in medical care.

The possible disadvantages of such a pattern would be an adverse public reaction to having chronic mental patients in units attached to general hospitals and the possible administrative difficulties of providing for these patients in the vicinity of general hospitals. Would these disadvantages outweigh the advantages? Only a pilot project could decide this. Could the number of long-stay patients attached to general hospitals in the Province be kept as low as 400? The accumulation of old people in the chronic wards of general hospitals could be prevented only if community services were adequate to help the familites look after the mentally handicapped. Would a community suffer from having more of its mentally disordered at home? Not likely, but careful evaluation of a proper pilot project would be needed before this could be answered with certainty.

(c) *Physicians* (3)

To what extent are New Brunswick's non-psychiatric physicians involved in the diagnosis and treatment of mental disorder, and to what extent can psychiatrists anticipate assistance from them in the future? There are 486 registered physicians in the Province, making a total of one to 1,238 population compared to about one to 800 in the rest of Canada. Of the 486, 97 are salaried physicians (mostly in the employ of the Provincial and Federal Governments) and 389 are in private practice. Of the 389 doctors in private practice, 154 are

specialists, and 235 work as general practitioners. Most private practitioners participate in the Maritime Hospital Services Association (Blue Shield), which is a prepaid program sponsored and supported by the New Brunswick Division of the Canadian Medical Association. As in other provinces, I talked about psychiatry with representative general practitioners in New Brunswick. They told me that all practising physicians (especially general practitioners) treat many confused, depressed, and anxious people. The complaints of these doctors in New Brunswick about psychiatry resemble the complaints of general practitioners elsewhere; it is difficult to get an emergency consultation, there are not enough psychiatrists available, some areas in New Brunswick have no consultants, many patients resent being admitted to the mental hospital at Lancaster—but it is not always possible to have a patient admitted to one of the two psychiatric units in general hospitals. There were emphatic complaints about the lack of services for treating alcoholics.

With more psychiatry now being taught in the medical school at Dalhousie, an increasing number of the general practitioners now acknowledge the responsibility of the family physician for most psychiatric problems. If the family doctor is to make his most useful contribution, he will need readily available emergency psychiatric consultation services no matter whether he practises in Saint John, or deep in the bush. This will require consultants located not only in the Moncton, Saint John, Fredericton triangle (and at Edmundston) but also at Newcastle, Bathurst, and Woodstock. It means greater flexibility in the admission of mentally disordered people to general hospitals, and better facilities throughout the Province for the chronically ill and for the aged confused.

(d) *Psychiatrists* (2)

There are 26 doctors employed full-time in psychiatry in New Brunswick. Seven of these have been certified as specialists by the Royal College of Canada (four at Saint John, two at Moncton, and one at Fredericton). Many of the remaining 19 are in training posts of practice on a limited licence which restricts them to provincial institutions; the Minister of Health is empowered to grant such limited licence to graduates of foreign medical schools without L.M.C.C.

It is obvious that only seven fully trained psychiatrists cannot provide (in addition to other duties) all the consultation services for nearly 400 medical practitioners. Just to make adequate consultation services available, New Brunswick would need more than 35 specialists in psychiatry. Among other obstacles to recruiting doctors into psychiatry, is the limited income of psychiatrists in this Province. It is estimated that the income of the best paid psychiatrist is less than half that of New Brunswick's radiologists. If psychiatrists are to be located in the upper Saint John Valley, or along the Bay of Chaleur, as well as along the Bay of Fundy, better financial rewards will be needed. Perhaps an extension of the present limited system of part-time government stipend, plus private practice rights, would help solve this problem.

5. Public Health Services in Psychiatry (2)

Mental Health Services comprise but one division of the services provided by the Provincial Department of Health. Other Divisions with responsibilities related more or less closely to mental health include Public Health Nursing,

Medical Health Officers, Rehabilitation, Hospital Services, and Child and Maternal Welfare.

There are 48 public health nurses in the employ of the Provincial Government; what they do resembles, in some degree, the work of a smaller number of Victorian Order of Nurses. Based on an estimate of one public health nurse for 5,000 people, New Brunswick would need 120 public health nurses just to perform the duties that public health nurses ordinarily carry out. If, however, the public health nurse was to have additional responsibilities based on a larger role in the community care of the mentally disordered, then an even greater number of public health nurses would be needed.

Four of New Brunswick's six Medical Health Officers are now fully qualified, and five more qualified officers are needed. If more community care is to be provided for the mentally disordered in New Brunswick, these Medical Health Officers will require better orientation in psychiatry.

At the present time, New Brunswick participates in the National Rehabilitation Program, and thus recovers from the Federal Government 50 per cent of the funds that the Province spends on certain rehabilitation projects; no psychiatric patients are rehabilitated through this program. Yet, most high-grade mental defectives, and many schizophrenics, should have special training and sheltered conditions for work and recreation. Surely these rehabilitation facilities should be available to this group, and should be a reasonable charge on Federal Rehabilitation Grant Funds.

6. Voluntary Agencies (4)

The New Brunswick Division of the Canadian Mental Health Association has 15 branches and local committees, and more than 20,000 members. It plays a useful role in mobilizing public opinion in support of improved services. It also supports legislative reform, and seeks funds for psychiatric research. The New Brunswick Division has actively supported the principle of developing local services under local boards, with these services supported by central financing.

The New Brunswick Association for Retarded Children is an active voluntary group whose contribution will be discussed under the section on mental retardation.

7. Special Problems

(a) *Child Psychiatry*

At the present time only the Provincial Hospitals at Lancaster and Campbellton provide in-patient services for emotionally disturbed or retarded children. A 240-bed Child Guidance Service is under construction at Saint John for both mentally retarded and emotionally disturbed children.

Children make up 30 per cent of the patients seen at the four mental health clinics; in order of frequency, the presenting problems of these children include mental retardation, anxiety, conduct disorder and speech defect. Most of these patients are referred by family doctors as well as welfare agencies and school systems. With New Brunswick's particular population distribution, child guidance services outside Saint John and Moncton are likely to continue to be closely associated with adult services.

(b) *Mental Retardation* (5)

In the two mental hospitals in New Brunswick, there are 60 retarded children, and an undetermined number of retarded adults. About 100 mentally retarded patients are admitted to institution each year, which is about the average admission rate in Canada.

With the completion of the 240-bed Child Guidance Service in Saint John there will be a special diagnostic and treatment center for mentally retarded children.

New Brunswick has an active branch of the Canadian Association for Retarded Children. This branch maintains twelve classes throughout the Province, and looks after 165 day pupils; for this it receives provincial assistance to the extent of $1,000 for each school, with $500 for each teacher, and $100 for each pupil. The Association is hard pressed to make up the balance of operating expenses and its officials have suggested increasing the $100 stipend to $300 per pupil.

The official policy of the Canadian Association for Retarded Children in New Brunswick recommends greater separation of the care of the mentally retarded from the care of other mentally disordered. The Association wants at least two more child guidance services similar to the one now being established at Saint John, and suggests that these be located at Edmundston and at Moncton. It also recommends that day care centers and small hostels be established throughout the Province. The Association Executive strongly recommends having trained counsellors to help and advise those parents who keep their mentally retarded children at home.

While one cannot question the value of the contribution of this Association toward improved care for the mentally retarded, nor the motives behind its plans for the future, there is some question about the wisdom of its drive to separate the care of the mentally retarded from that of other mentally disordered people. Could not the same community worker follow up both the mentally retarded and the mentally ill, or even better, could not this be best done by a properly trained public health nurse, who could integrate the health needs of this group with other health needs in the community?

(c) *Other Professional Staff* (6)

There are 1,675 registered nurses actively employed in New Brunswick; these nurses mostly come from the 13 schools of nursing in 13 of the larger general hospitals. It is obvious that this group will come in contact with large numbers of mentally disordered people, and that their undergraduate training should prepare them for this.

There are 15 psychologists employed in the mental hospitals and in the mental health clinics.

8. Conclusion

(i) New Brunswick has established four full-time Mental Health Clinics, which provide useful consultation and treatment services, and will furnish much information on the role of such services in the future; much more service of this type is needed.

(ii) In Saint John, New Brunswick is developing a 240-bed Child Guidance Service for emotionally disturbed and mentally retarded children.

(iii) There is an active branch of the Canadian Association for Retarded Children pressing for other improved services for the mentally retarded.

(iv) Two of New Brunswick's ten larger general hospitals have psychiatric units with a total of 40 beds.

(v) The two large mental hospitals in New Brunswick are handicapped by lack of staff and by their isolation from other community psychiatric services; alternate patterns of providing treatment for psychiatric in-patients are needed.

(vi) The 386 practising physicians in New Brunswick who are not psychiatrists are handicapped by the lack of psychiatric consultation service.

REFERENCES

(1) Annual Report of Mental Health Services of New Brunswick for year ending March 31, 1963.

(2) *Department of Health, Province of New Brunswick,* brief presented to the Royal Commission on Health Services, November 9, 1961.

(3) *The New Brunswick Medical Society,* brief presented to the Royal Commission on Health Services, October 14, 1961.

(4) *The New Brunswick Division of the Canadian Mental Health Association,* brief presented to the Royal Commission on Health Services, November 10, 1961.

(5) *The New Brunswick Association for Retarded Children,* brief presented to the Royal Commission on Health Services, November 10, 1961.

(6) *The New Brunswick Association of Registered Nurses,* brief presented to the Royal Commission on Health Services, November 9, 1961.

CHAPTER 6

TRENDS IN PSYCHIATRIC CARE IN QUEBEC

1. Introduction (1) (2) (3)

In the Province of Quebec in 1962, about 20,000 hospital beds were being used for the care of the mentally disordered. These beds were in 40 institutions which included 13 general hospitals with psychiatric units, and they constituted 40 per cent of the Province's 55,000 beds for illnesses of all types.

This means that Quebec has 404 psychiatric beds per 100,000 population, which is near the Canadian average of 350 beds per 100,000; this is almost the only manner in which the psychiatric services in Quebec resemble the psychiatric services in the rest of Canada. Psychiatry in the Province of Quebec differs from psychiatry in the other nine provinces in many ways; the organization is different, financing is different, and often even the goals of psychiatry seem to differ in the two areas. Yet a careful examination of these differences, and of the great changes taking place in psychiatry in the Province, provides many clues to the changes now taking place in psychiatry everywhere.

It is easy to find explanations as to why psychiatry in Quebec differs so much from psychiatry in the rest of Canada. With its 594,860 square miles, Quebec has the largest area of any province, yet its population is concentrated along the St. Lawrence Valley and in the eastern townships. This partly explains why Quebec psychiatric services tend to be overcentralized.

The 5,142,000 people living in the Province of Quebec in 1962 comprised two groups differing sharply in race, language, religion and political leanings. Only 15 per cent of this population is predominantly English speaking; in culture and tradition, the Anglo-Saxon group of 800,000 relates itself to the inhabitants of the remaining nine provinces, which are, in the main, English speaking. The psychiatrists in the Province of Quebec who serve the English population are also oriented towards their psychiatric colleagues in the other Canadian provinces. In Quebec in the past, French-speaking psychiatrists have, for understandable reasons, leaned towards the psychiatry of France. Yet real differences in outlook stand between the France of the post-Revolutionary Period, and the Province of Quebec whose cultural traditions more often than not antedate the 1789 Revolution. In many instances, therefore, French Canada has developed unique, albeit predominantly Gallic patterns, and this uniqueness certainly applies to psychiatry. The psychiatry of most of Quebec has no counterpart elsewhere.

With the Catholic population making up almost 85 per cent of the Province's total, and with the Church having its traditionally paternalistic interest in the

welfare of its people, religious orders have developed most of the psychiatric services for the French-speaking citizens of the Province. In the same manner the Church of medieval England had developed that country's first psychiatric services, and it operated these until Henry VIII broke with Rome during the 16th Century. The Sisters of Providence and the Sisters of Charity operate the 5,600-bed Hôpital Saint-Jean-de-Dieu and the 5,100-bed Hôpital Saint-Michel-Archange in Montreal and in Quebec City respectively. Since psychiatry in French-speaking Canada has centered in these two institutions, the two religious orders have long dominated mental health services in the Province. For many years the religious orders have provided dedicated care for the mentally disordered. Certainly in no other place in Canada has psychiatric care been so kindly given, or so highly motivated; yet some change is needed now. When practising psychiatry was primarily a question of looking after the mentally handicapped, little professional training was required; now that scientific advances have increased the knowledge of the cause and treatment of mental disorder, more medical influence is required.

Although great changes are bringing new patterns of psychiatric service throughout Canada, the speed of change has had its greatest acceleration in French-speaking Quebec; most of these changes have occurred during the past five years. With the election in 1960 of a Provincial Government more or less dedicated to change the transition speeded up. In psychiatry the hand of this Government was forced by the efforts of a group of young French-speaking psychiatrists who wanted many changes in a hurry. Many of this group had been stimulated by their post-graduate training in the United States and in France, and, as so often is the case, they demanded changes that were more radical than those they had seen below the border or in Europe.

A stimulus for change in psychiatric services also came from other groups in the Province of Quebec. The psychiatrists at centers like the University of Montreal, the Institute Albert Prévost, Hôpital Ste-Justine, Hôpital Notre-Dame, the Allan Memorial Institute, the Montreal General Hospital, the Verdun Protestant Hospital, and the Queen Mary Road Veteran's Hospital had always been in the forefront of those introducing new ideas in psychiatry. Such advances as the Open Door, the Day and Night Hospital, and chlorpromazine for schizophrenics either originated in Montreal or were first promoted in Canada by psychiatrists from this group. Undoubtedly, a reaction to developments in English-speaking Quebec also increased a desire for change among French-speaking psychiatrists. At the same time there was pressure from the Quebec College of Physicians and Surgeons, the Association of Psychiatrists of Quebec, and the Quebec Division of the Canadian Mental Health Association, and from the Quebec Federation of Labour and the Federation of Catholic Syndicates; these organizations wanted the Province to develop new patterns in psychiatric services.

In 1961, responding not unwillingly to this pressure, the Government of the Province appointed a three-member *Commission d'étude des hôpitaux psychiatriques*. Dr. Dominique Bédard, a psychiatrist from Quebec City chaired the Commission, and the other two members were Dr. Denis Lazure, Chief of Psychiatry at Ste. Justine Hospital, Montreal, and Dr. Charles A. Roberts, Superintendent of the Verdun Protestant Hospital. The Commission's report to the Provincial Government gives an excellent description of the psychiatric hospital services in the Province, and includes many useful recommendations. In setting out to change its pattern of psychiatric service, the Government of the Province has used this report as an operational blueprint. All three members of

the Commission, Drs. Bédard, Lazure and Roberts have since been appointed to senior administrative posts in the Government's psychiatric organization.

In collecting data for my study on psychiatric services in Quebec, I am greatly indebted to Drs. Bédard, Lazure and Roberts, not only for the information that I have secured from their report, but also for personal communications and advice. Their *Rapport de la Commission d'étude des hôpitaux psychiatriques* is an excellent document and warrants wide circulation.

2. Services for the Mentally Ill and Mentally Retarded (2) (4)

Since, generally speaking, the mentally ill and the mentally retarded in the Province of Quebec are cared for in the same institutions, the hospital care of these two groups will be described together. In the nine English-speaking provinces, the hospital services for the mentally disordered are operated by the Provincial Governments. In the Province of Quebec, on the other hand, having set up legislation governing psychiatric hospital care and having through taxation secured most of the funds for the operation of these psychiatric services, the Provincial Government has delegated its operational responsibility to other organizations—either to religious orders or to other charitable bodies. Recently, requests for changes in the pattern of psychiatric care have resulted in the present Provincial Government taking a more active interest in the operation of the psychiatric hospitals. Now through legislative change, and new methods of financing, it is trying to find new ways to solve old problems.

In the past, psychiatric services in Quebec have been highly centralized—even to the point of sometimes losing touch with local communities. For patients of Roman Catholic faith (most of whom are French-speaking), hospital services have been, for the most part, at Saint-Jean-de-Dieu in Montreal and at Saint-Michel-Archange in the City of Quebec. For patients of Protestant faith (most of whom are English-speaking), hospital care has been provided at the Verdun Protestant Hospital in the City of Verdun. Even though most Catholic patients are French-speaking and most Protestant patients speak English, this is not always the case. To facilitate diagnosis and treatment, the Commission has wisely recommended that the division of patients between the Verdun Protestant Hospital and the two other large hospitals be on the basis of language rather than religion.

The Hôpital Saint-Jean-de-Dieu was founded in 1875, and is now operated by the Sisters of Providence; with 5,600 patients, it is the largest mental hospital in Canada. Since Saint-Jean is owned and operated by a religious order, most of the members of its Board are from that Order. The Commission has recommended that the Board have a wider representation of interested groups and professions.

With past emphasis having been on care and custody rather than on therapy and rehabilitation, the authority and responsibility of the medical superintendent at Saint-Jean's has been limited. This has made it more difficult to recruit enough qualified medical staff. For its 5,600 patients, the Hôpital Saint-Jean-de-Dieu has but 20 full-time psychiatrists assisted by 33 part-time physicians, whereas the minimum recommended by the American Psychiatric Association for 5,600 patients is 75 full-time doctors.

The Commission has advised reorganizing the medical staff in accordance with patterns usually found in general hospitals, thus increasing the responsibility and interest of this group and facilitating recruitment. Specifically it

recommended giving the medical superintendent more responsibility and having a Medical Admissions Committee that would decide which patients could most appropriately be treated in this hospital. Perhaps such a reorganization of responsibilities could be a first step towards closer liaison between this huge mental hospital and the general hospitals in the City of Montreal. This could be a move towards ending the isolation of psychiatry and towards integrating psychiatric services with the rest of medicine. It could also result in an active resident training program at Saint-Jean-de-Dieu where, at the time this study was prepared, there were no residents.

Like other Canadian mental hospitals, Saint-Jean-de-Dieu has had to struggle with severe overcrowding. In an attempt to cope with this overcrowding, the hospital administration has established satellite institutions to which surplus patient population has been moved. These institutions include the 130-bed Saint-Benoît Hospital in Montreal and the 1,170-bed Hôpital Mont-Providence located on the Isle of Montreal near that City (Hôpital Mont-Providence also serves all categories of retarded children). The disadvantages of moving patients to these satellite institutions are clear. Since only long-term patients have gone to such places as Saint-Benoît and Mont-Providence, all first admissions have been made to the parent hospital—Saint-Jean-de-Dieu. Because of its size, this institution is of necessity impersonal and so contact between its physicians and the relatives of its patients has been limited. Moreover, most patients were moved to the satellite institutions on the basis of diagnosis and chronicity, rather than because of geographic origin. Hence local populations have had little reason to be interested in these institutions, or to have contact with them. This has adversely affected the visiting of relatives and the recruitment of staff. Most of the patients moved to these hospitals in the country have been under long-term care; they included a large number of schizophrenics and mental defectives. Unfortunately, staff limitations have often precluded accurate evaluation of mental state, and so for some of the patients who have been moved, it is hard to tell whether their handicap is due to mental retardation, to schizophrenia, or to organic deterioration.

The weight of chronicity, and the lack of active rehabilitation has, in the past, made the satellite institutions unattractive as places of employment for the professionally ambitious. As a result, until recently, most medical care has been given by part-time local physicians with spasmodic visits of psychiatrists from Saint-Jean-de-Dieu. Meanwhile, the mentally sick from areas surrounding the satellite hospitals could not be admitted to these centers so near home, but had to go a great distance to Saint-Jean-de-Dieu. These disadvantages had increased the clamour for decentralized services.

During the mid-1950's, the Government of the day spent nearly $50,000,000 building four large psychiatric hospitals, two of which (Hôpital St-Charles-de-Joliette, at Joliette, and Hôpital des Laurentides, at l'Annonciation) were within 100 miles of Montreal, and intended as satellites of Saint-Jean-de-Dieu. Fortunately, in 1961, *La Commission d'étude des hôpitaux psychiatriques* recommended that instead of taking overflow of patients from Saint-Jean, that St-Charles and the Laurentides serve as community psychiatric hospitals for the areas in which they were located. The Government has accepted this recommendation, and even though large numbers of chronic patients had already been transferred, and must remain, these two institutions (St-Charles now with 1,400 patients, and the Laurentides with more than 800) now also serve the counties in their immediate vicinity.

In May 1963 I visited the Hôpital St-Charles-de-Joliette; it was in the midst of its transition. Its newly constituted Board had just appointed to the superintendency an active, well-qualified psychiatrist, Dr. Pierre Martel; he was busily engaged in making changes. St-Charles was built in 1956 at a cost variously estimated of from $15-20,000,000. Because of its fortress-like lines, its barred windows, and barbed wire fence rimming the airing courts, it provided a forbidding exterior—not yet softened by the still underdeveloped landscape. Inside, the appointments were moderately luxurious. One of the early goals of the new staff was to remove the bars and barbed wire which were the prime vestiges of custody.

By 1963, Hôpital St-Charles-de-Joliette was serving a population of 310,000 in an area based on a 50-mile stretch of the St. Lawrence River, and extending north for 150 miles. By this time the practice of transferring long-stay patients from Saint-Jean-de-Dieu to St-Charles had been stopped, and in 1963, 189 patients were admitted from the local area served by St-Charles. The reorganized administrative set-up established a broadly based Board. The medical staff was organized along lines that resembled most general hospitals with the medical superintendent made chief of staff; he was also given considerable authority in regards to admission of patients and maintaining professional standards. This was a far cry from the previous practice of having a local general practitioner provide the medical service for this hospital.

Even so, this huge, white, ungainly looking institution still stands as a structure apart, and in the minds of the public, its appearance symbolizes its separateness. Certainly the people of Joliette do not accept it in the same way as they accept their local general hospital. If it is to achieve this acceptance, I believe that it will have to provide some non-psychiatric medical service to the community; perhaps if some Joliette mothers had their babies in Hôpital St-Charles, or if their children were admitted for tonsillectomy, the structure would lose much of its stigma and apartness. If such integration of this big institution could be achieved, still further integration of psychiatric services could be made possible by establishing psychiatric units in the general hospitals of the district.

Being thus isolated from the community and from the rest of medicine, institutions like St-Charles have had great difficulty recruiting staff. Despite its professional shortcomings, psychiatrists are willing to work in the Hôpital Saint-Jean-de-Dieu because of the cultural advantages and the professional contacts from living in Montreal; but such does not apply to living in Joliette. Special inducements are now needed to get top-flight professional staff to work in hospitals like St-Charles. True, one attraction is a chance to pioneer, but as an effective inducement this can only last so long. It seems to me that better integration with the rest of the local medical services would be the best way to improve recruiting. Of course, integration into the community life will improve with the continued admission of patients from the local area, especially if there are no more transfers of long-stay patients from Saint-Jean-de-Dieu.

This decentralization of admission will also have some beneficial effect on Saint-Jean-de-Dieu. With St-Charles, Laurentides, and other centers admitting from local areas, it should become possible to stop Saint-Jean-de-Dieu from becoming bigger.

The Hôpital Saint-Michel-Archange, with a patient population of 5,100, is situated at Quebec City. It serves the French-speaking population of the lower St. Lawrence Valley and all of the eastern part of the Province of Quebec.

Established in 1845 as a private mental hospital, it was acquired in 1893 by the Sisters of Charity, and since that time has been operated by this Order. During the past several years it has developed closer ties with the University of Laval, having, in 1963, 20 residents-in-training in psychiatry. In addition to these graduate physicians-in-training, the hospital has a staff of 18 full-time doctors. The 5,100 patients included 760 mentally retarded persons, and more than 200 epileptics.

Like Saint-Jean-de-Dieu, Saint-Michel-Archange has striven to cope with its overcrowding by acquiring or affiliating with other institutions; to these distant buildings it has repeatedly transferred long-stay patients. For the most part, these satellite institutions have been technically under the management of the administration at Saint-Michel-Archange. These peripheral facilities include the 1,130-bed Hôpital Sainte-Anne at Baie-Saint-Paul—50 miles downstream on the north shore of the St. Lawrence, and the 1,463-bed Hôpital Saint-Julien at St-Ferdinand—65 miles south of Quebec City, and the 750-bed Hôpital Saint-Elizabeth at Roberval—150 miles north of Quebec City. These institutions have suffered from being satellites of Saint-Michel in the same way as St-Charles and the Laurentides suffered from their relationship with Saint-Jean-de-Dieu in Montreal. They have absorbed long-stay patients from Saint-Michel-Archange, and have not served the areas in which they are situated. Being isolated and treating chronic patients only, it has not been easy for them to obtain professional staff; for the most part, part-time general practitioners have provided the medical service.

It is now planned to decentralize and to equip these local institutions so they may admit and treat psychiatric patients from the area in which they are located. Where possible, it would seem wise to consider further integration with non-psychiatric health services—even to the extent of having local general practitioners admit and treat their own psychiatric patients—including some who are physically ill rather than mentally sick.

Here I must mention one change resulting from the recommendations of the Commission. According to the plan of the construction program of the mid-1950's, which led to the building of St-Charles, Laurentides, and Sainte-Elizabeth, the Government was also building a 1,200-bed institution called Le Pavillon St-Georges in the Sherbrooke area. Recently, however, the Government has accepted the Commission's recommendation that this unfinished institution be assigned to some purpose other than to psychiatric care, and that the population of the Sherbrooke region be served by psychiatric services established in the local general hospitals. No incident could better reflect the changing views on psychiatry in the Province of Quebec, and I doubt whether anywhere else one could find a more significant or heartening change in plan and action.

In discussing psychiatric services in the vicinity of Quebec, mention must be made of the Clinique Roy-Rousseau. This is a 175-bed institution adjacent to Hôpital Saint-Michel-Archange, but administered separately from it. It serves a short-term clientele which includes psychotics, alcoholics, and neurotics. Patients have always been admitted here without the loss of civil privileges formerly resulting from admission to Saint-Michel-Archange. Because the institution is smaller and better equipped, and because it caters to short-term patients, its operational costs have been necessarily higher. Through a special arrangement similar to that set up for the Institut Albert Prévost and the Allan Memorial Institute, the Roy-Rousseau Clinic has been financed under the Hospital Insurance Plan. It has catered to the type of patients which should have been

treated in the psychiatric services of the general hospitals in Quebec City—if these hospitals had had psychiatric services.

The Verdun Protestant Hospital (5) provides most of the hospital care for the mentally disordered of the Province's 800,000 Protestants; most of this Protestant population is English-speaking. Additional in-patient care is furnished by psychiatric units in Montreal's general hospitals, and for the mentally retarded by the Cecil Butters Memorial Hospital at Austin, Quebec (about 80 miles south-east of Montreal). The Butters Memorial looks after about 300 retarded patients.

The Verdun Protestant Hospital was founded in 1890 to care for mentally disordered patients from the non-Catholic population. It has always been administered by a Board comprised of private citizens from a variety of backgrounds. The Board delegates broad authority to the medical superintendent.

Until 1962, the operation of the Hospital was financed primarily through a Quebec Government grant—based on a fixed per diem. By 1962, this rate was $2.75 a day per patient. The three-man Commission studying psychiatric hospitals in Quebec recommended that an annual estimate of expenditures based on needs replace the fixed per diem, and the Government agreed.

The patient-population in 1962 was 1,530 compared to a 1959 high of 1,650 beds. It has been the policy of the Verdun Protestant Hospital not to admit mental defectives, alcoholics, and epileptics, although many members from these groups were admitted from time to time. The Hospital now has plans for a 200-bed unit for mental defectives, as well as plans for units for psychopaths and disturbed adolescents.

In 1962, the staff of the Hospital included eight qualified psychiatrists and 12 residents-in-training. Compared to other Canadian mental hospitals, the staff at VPH has had a high reputation for professional competence; it pioneered the use of tranquilizing drugs in Canada. It has also been more fortunate than many other hospitals in Quebec in obtaining social service workers, psychologists and occupational therapists.

As elsewhere in Quebec, efforts are being made to integrate the services of the Hospital with services in the community; it is hoped to have its medical and surgical service covered by the Quebec Hospital Insurance Plan.

One gets the impression that administration of this Hospital has made the most of the rather meagre resources that it had at its disposal. Whether the Hospital will continue in its present form will depend to some extent on the future pattern of psychiatric services in Canada. If there is fairly complete integration of psychiatry with other medical services, then the present institution should either disappear or provide for a definite segment of the population a broad spectrum of all types of medical services, including psychiatry.

3. Special Problems of Quebec's Institutions for the Mentally Disordered

As elsewhere, the problems of the institutions housing the mentally ill and the mentally retarded in Quebec include difficulties arising out of (a) adverse community attitudes, (b) staff recruitment, and (c) finance. In the above brief

description of some of the Quebec institutions, reference has already been made to some of these problems, but here they will be discussed in greater detail. Although many of these difficulties are common to all mental institutions everywhere, there are some regional differences peculiar to Quebec.

As in other provinces, the isolation of psychiatry has been the major handicap. The fear that the public still retains of the mentally ill is evident in one large Quebec institution that maintains a police force—not only to protect the institution's equipment from outside marauders but, presumably, also to protect the public from the patients. Such should not be necessary in a modern psychiatric program, especially if the State separately provides adequate psychiatric services in its penal institutions for those charged with crime who become mentally ill. Further evidence of the public's irrational fear of violence from the mentally ill is shown in the rigid segregation of the sexes which, until recently, has prevailed in most Quebec mental institutions. Let us hope that with increased public understanding some of these security measures will be relaxed and the doors opened. Let us further hope that the public will accept the trend towards more foster homes, half-way houses, and sheltered workshops. It should also provide better rehabilitation for those who have been sick, and a better chance at early re-employment.

Because of the past shortage of professional staff in the Quebec institutions it has not been possible to maintain accurate classifications of all patients. Many patients had to be moved from one institution to another before adequate study of their disorders could be made. This need for better professional evaluation of the mentally sick also applies to those being admitted to institution for the first time—certainly those in charge of admissions should be professionally qualified.

This need for a higher ratio of professionally skilled staff pertains throughout the Province's psychiatric institutions. As mentioned above, religious orders have, in the past, provided excellent care for the mentally disordered. However, with the recent increase in scientific psychiatric knowledge, the hospitals need more persons qualified to diagnose and treat mentally sick people.

Since the forerunners of today's mental hospitals were asylums to house the needy, it is understandable that much of the present accommodation is unsuitable by today's hospital standards. Certainly where these institutions are still to be used in future, the large wards must be broken down into much smaller units, and there must be fewer patients for each staff member.

Even with improved salaries for medical staff (certified psychiatrists in the Province of Quebec may now receive from $13,000-$20,000 annually for 35 hours work each week) as elsewhere the institutions suffer from marked shortage in qualified psychiatrists. This throws more responsibility on the nursing staff, yet in obtaining qualified nurses, the Province of Quebec has fared worse than most other Canadian provinces. Although it is difficult to secure accurate statistics for comparing Quebec with other provinces, it appears that in 1961 the total number of staff per 1,000 patients in Quebec institutions was well below the average of 425 per 1,000 in all Canadian mental hospitals.

Some interesting efforts have been made to solve the staff shortage. At St-Charles-de-Joliette I saw a group of Spanish-speaking Sisters of the Carmelite Order who had come to look after French-speaking patients; despite the language handicap they were doing very well indeed. The Commission had already pointed out the disadvantages of having patients who spoke only one language treated by staff who spoke only another. It recommended that

English-speaking Catholics be treated at the Verdun Protestant Hospital, and French-speaking Protestants in one of the institutions where French was the customary language.

The shortages of psychiatrists and nurses were aggravated by like shortages of other professional personnel. In 1961, Saint-Jean-de-Dieu had but one psychologist, although the APA minimum called for 23 psychologists for a patient-population of 5,600. Similarly, there was but one social worker when the need was for 28, and one qualified occupational therapist where 29 should be the minimum. Admittedly, no Canadian mental hospital has reached this APA standard, but few other mental hospitals were having as much difficulty obtaining professional staff as some of the institutions in Quebec. These shortages were recognized by the Commission, which made vigorous recommendations for an increase in all professional personnel.

One reason commonly given for defects in the institutions was their shortage of funds. That lack of money was not really the main problem was made clear by the expenditure during the 1950's of more than $50,000,000 for building four large mental hospitals, which, in the light of current concepts, were obsolete by the time they were opened. At the same time, institutions such as Saint-Jean-de-Dieu and Verdun Protestant Hospital were receiving per diems of only $2.75 per day per patient, which was well below the atrociously inadequate average for all mental hospitals in Canada. It is interesting to note that the Quebec Hospital Insurance Plan at the same time was paying the Roy-Rousseau Clinic, the Institut Prévost and the Allan Memorial Institute from $10.00 to $25.00 a day. Even allowing for the effect on costs of having voluntary services provided by members of religious orders, and for the relatively smaller overhead of bigger institutions, it is obvious that too little money was made available for the care of most patients. The Commission has said that the practice of paying a fixed per diem is detrimental to good service, and the Government has looked favourably on the alternative of establishing annual budgets based on needs.

Although most of the remarks in this section include services for all types of mentally disordered, some special comments should be made about the care of the mentally retarded. Other than the three smallest Alantic Provinces, Quebec is the only Province which has not established well-defined separate facilities for its mentally retarded. As mentioned before, about 300 retarded patients from the English-speaking population are cared for in the Cecil Butters Memorial at Austin; the Provincial Government pays a per diem rate to the private organization that operates this institution. Most of the hospitalized retarded from the French-speaking population have been transferred from the two main hospitals, Saint-Jean-de-Dieu and Saint-Michel-Archange to such affiliated institutions as Mont-Providence and Sainte-Anne.

Changes in the care for the mentally retarded are long overdue and some are coming. I visited the Institut Doréa—a children's center at Franklin, Quebec, that is a model institution looking after 155 retarded boys with I.Q.'s ranging from 60 to 80. This may not be the exact prototype of future care for the mentally retarded in the Province, but what is learned at experimental centers like this one will give leads to the type of facilities needed. Certainly the days are numbered for keeping hundreds of mentally retarded people in huge institutions —often far distant from their homes and relatives.

4. Community Care

The trends in present-day psychiatry are towards early discharge of mentally disordered persons to the community. This increase in the extent of community treatment of mental illness makes necessary better follow-up facilities for discharged patients, and more people in the community able to treat many mental patients without need for hospital admission.

Only psychiatrists can provide the leadership needed to develop such a program in the Province of Quebec. In other areas such leadership has usually come from the staff of mental health clinics and from the psychiatric out-patient departments of general hospitals. In Quebec most of the out-patient facilities are located in the City of Montreal, and of these, most are attached to general hospitals; a few out-patient units are scattered through other parts of the Province, as at Sherbrooke, at Valleyfield, and at Chicoutimi. In Quebec City some out-patient and in-patient services are now provided on a private basis at l'Hôpital St-Sacrement, at the Hôtel-Dieu, at l'Hôpital St-François-d'Assise and at l'Hôpital l'Enfant-Jésus.

Unfortunately, most of the psychiatrists, psychologists and social workers attached to these out-patient units keep so busy providing service for patients that they have little time left to train and to supervise others in the community who might help with the care of the mentally ill. They should train and supervise those professionals whose work brings them into contact with mentally ill patients. Thus they should enlist help from family physicians, welfare officers, school teachers, and from the staff of public health units. To work with these people on patients' problems would provide the best training, but to do this on a large enough scale to be useful would require more consultation services than are now available; these services could either be at existing mental hospitals, at psychiatric units in general hospitals, or in community units such as the Mental Hygiene Institute of Montreal.

It is particularly difficult to follow up discharged mental patients in the Province of Quebec. Too few professionals (especially those in the English-speaking facilities) are skilled in both languages. Also most of the Province's psychiatrists are located in Montreal and Quebec City.

The follow-up situation is much better in Montreal, where hospitals like the Notre-Dame Hospital and the Allan Memorial Hospital have good home-care programs. The Montreal General Hospital maintains good community contact through its highly developed day-care and night-care centers. However, even in Montreal psychiatrists should do more about delegating responsibility for psychiatric patients to family doctors, and should provide better psychiatric training for physicians in general practice. Outside Montreal, the patients are so far from psychiatric help that it is most important to bring the family doctor into the treatment picture, and to use the public health workers in the after-care of psychiatric patients. The Administrator of Psychiatric Services in the Province of Quebec will find it hard to train and involve these persons in community psychiatric work, yet unless he does involve them, he will have trouble extending community care; without such an extension in community services, patients would have to remain much longer in hospital.

5. General Medical Services and Psychiatry

(a) *General Hospitals* (6)

In the Province of Quebec, more than 33,000 of the total of 55,000 hospital beds are in general hospitals. This gives Quebec a ratio of almost six beds per 1,000 and makes it the ninth province on the list in the provision of general hospital beds.

In 1961, the Province of Quebec had (not counting services for Veterans) thirteen psychiatric units (with a total of 411 beds) in its general hospitals. Twelve of these units were in the City of Montreal—the thirteenth at Chicoutimi; other psychiatric units were planned for other general hospitals, including one unit at Levis.

Most authorities today recommend big increases in the number of psychiatric beds in general hospitals, and some authorities suggest that from 5 to 20 per cent of all beds in general hospitals be designated for psychiatric patients; the percentage depends on whether or not the particular expert considers mental hospitals to be obsolete. In the Province of Quebec, the number of beds in psychiatric units in general hospitals is far below the lesser of these two figures. Even those advisors who still believe in building big or small mental hospitals would recommend that a population of greater than 5,000,000 would need more than 411 psychiatric beds in its general hospitals.

Some of the advantages of treating more of the mentally ill in general hospitals, rather than mental institutions, include less stigma, better staffed and better equipped units, and closer contact with general physicians; for example, having units in general hospitals makes it much easier to instruct and inform most general practitioners about psychiatry. Noting these advantages, the Quebec Commission studying psychiatric hospitals has recommended that no new general hospital be built without including a psychiatric unit. This is in line with the recommendations of the Canadian Psychiatric Association that every general hospital with more than 200 beds should have a psychiatric unit (also approved by the Commission).

(b) *Family Physicians* (7) (8)

The Province of Quebec has more than 6,000 physicians in practice, all of whom see large numbers of neurotic and psychotic patients in their offices. Since only a small percentage of these patients can be referred to psychiatric clinics or to psychiatric consultants, psychiatric treatment for most must come from their family physicians.

In recognition of this, the three medical schools in Quebec continue to improve their undergraduate psychiatric teaching for medical students; however, doctors who have graduated some years ago have had limited opportunity for psychiatric instruction. Some of the most useful instruction can come during contacts between a consultant and a general practitioner working together on a case, but most psychiatrists are too busy treating patients to be able to spend much time with general practitioners and, unfortunately, most general practitioners do not realize that they can get useful instruction from psychiatrists.

Besides adding more psychiatric units to general hospitals, one other way to assist the general practitioners to do better psychiatry would be to encourage them to admit and treat their own psychiatric patients in these units, in collaboration with psychiatrists. Not only could this improve the psychiatric skill

of the general practitioner, but it also would result in many psychiatric patients getting better treatment than is now possible.

But few general hospitals as yet have psychiatric services to which general practitioners can admit their patients for treatment. Until general hospitals can make such units available could not general practitioners be encouraged to admit and treat their patients in the existing psychiatric hospitals? Could this not be done in Saint-Jean-de-Dieu, in Saint-Michel-Archange, at Verdun Protestant Hospital, at the Hôpital Laurentides and at Hôpital St-Charles? I realize that this change would require good leadership and much patience on the part of the psychiatrists, and a big change in arrangements for the general practitioner. Certainly the general practitioner would need help with consultations, and he would need arrangements so that he might be recompensed for the time he took treating patients in mental hospital. Such a program presents many difficulties, but so does the present situation with thousands of anxious, confused, and depressed people having such limited access to doctors trained in psychiatry.

6. Special Problems

(a) *Child Psychiatry* (9)

Like other psychiatric services in the Province of Quebec, child psychiatry has developed principally in the cities of Montreal and Quebec. Montreal has four centers for the diagnosis and treatment of the psychiatric problems of children. These treatment centers include the Department of Psychiatry at Ste-Justine Hospital, where in 1961 seven child psychiatrists had 150 children in treatment. There are also Departments of Psychiatry at the Montreal Children's Hospital and child psychiatric services at the Mental Hygiene Institute, and at the Jewish General Hospital.

By 1961, Quebec City had but one child psychiatrist, but nonetheless, with the help of other psychiatrists and paediatricians, Quebec City at that time had two out-patient clinics in operation for the treatment of children with psychiatric problems.

In the face of proven need, the services listed above are woefully inadequate to deal with the emotional and intellectual problems of children in a population totalling more than 5,000,000 and spread over so large an area. Obviously, the present child psychiatric services must provide a nucleus for pschiatric research and teaching. The research should include studies on the development of child psychiatric services which would be helpful to the administrators of the Provincial psychiatric program. In treating mentally disordered children, assistance will be needed from teachers, paediatricians, family physicians, and many others. Hopefully, it will be possible to get these people to provide the help they could, but only if the leadership comes from the Province's child psychiatrists.

(b) *Care of the Mentally-ill Aged*

As in other provinces, Quebec's mental hospitals look after a large number of aged psychotics; these include patients admitted recently with chronic brain damage, as well as schizophrenics who have been in hospital for a long time. It is estimated that 30 per cent of the patients in the Verdun Protestant Hospital are more than 65 years old. It is difficult to estimate the number of mentally disordered old people in institutions (other than mental hospitals) operated by charitable organizations. Since Quebec has long had a tradition of having

religious orders care for its handicapped, it is obvious that a large number of mentally disordered aged are in facilities set up for other old people. As long as these groups receive psychiatric help when they need it, the practice of caring for confused old people in homes for the aged should continue. To provide professional assistance for the aged, the Province needs well-organized geriatric services in its general hospitals. These centers could provide diagnostic and consultation services, and help plan programs of care and re-activation. Probably they are best run by internists interested in geriatrics who should have close contact with family doctors and psychiatrists.

(c) *Psychiatric Legislation and Forensic Psychiatry* (10)

Generally speaking, over the past 100 years, psychiatric legislation in Quebec has been less restrictive than in the other Canadian provinces. This has enabled the Government to delegate the responsibility of caring for the mentally disordered to religious and charitable organizations. Hence psychiatric care in Quebec has developed on a private rather than State basis.

During the past 15 years the changes in mental health legislation in Quebec have mirrored the changes in other provinces. In 1950, the latest complete revision of the Mental Health Act made the customary allowances for certification by physicians, for voluntary admission and included measures (acceptable at that time) for safeguarding the rights of patients and of the community.

In line with trends elsewhere, those who administered psychiatric services in Quebec have recently sought to change this earlier legislation. They want to make admission to mental hospital the same as admission to general hospital—except for the small group of patients who aggressively resist. They also have sought to have a patient's competence to administer his financial affairs kept as a separate issue from his need for treatment. So far it has only been possible to change legislation in regards to competency; by a 1963 amendment it became no longer mandatory for the Public Curator to take over the administration of an admitted patient's estate. Whether or not he shall take over this administration now depends on the advice of the Medical Superintendent.

In the Province of Quebec, the care of the mentally disordered charged with crime, or serving sentence, has repeatedly raised storms. The psychiatric service at the Bordeaux Prison in Montreal has been subject to much criticism. Currently there are plans to build new maximum security units in Montreal and in the City of Quebec. It would seem wise to keep such units more closely related to prison services than to the psychiatric services set up for the rest of the population. The ordinary psychiatric hospital has not done a good job looking after psychopaths and persons serving sentence, and the presence of such people in psychiatric units of general hospitals has handicapped efforts to treat those other patients who do not require the same security measures. At the same time, it would seem that those who administer prisons need to know a good deal more than they now do about human behaviour, and having to administer psychiatric treatment services could help increase their knowledge and possibly improve their handling of prisoners of all types.

(d) *Psychiatry in Medical Education*

Trends towards the community treatment of the mentally disordered point up the need to have general practitioners, and other non-psychiatric physicians,

better instructed in psychiatry; partly this is the task for undergraduate teachers in psychiatry, and the medical schools in Quebec are doing something about it. At the same time, the Province needs more qualified psychiatrists to consult with family physicians and others in the community, to treat patients with particularly difficult problems, to teach and to do research; this requires more post-graduate training as well as improved recruiting.

In the training of psychiatrists, the Department of Psychiatry at McGill University, both in the quality and the quantity of its teachers, has maintained one of the leading centers in the world. The University of Montreal now has a group of younger psychiatrists with the skill and the interest to give leadership in post-graduate training. It is hoped that the interest and the efforts of this group will be recognized by those planning psychiatric services in the Province. The psychiatric services for the French-speaking portion of the population need a much greater number of qualified psychiatrists, especially outside of Montreal. However, both the University of Montreal and Laval University are establishing diploma courses in psychiatry.

(e) *Private Psychiatry*

Montreal undoubtedly leads Canada in the number of private psychiatrists, especially for the English-speaking portion of the population; this reflects the activity of its post-graduate training program. Fortunately, most private psychiatrists have some contact with publicly financed psychiatric facilities. The Provincial Government has made it possible for many of the psychiatrists who spend most of their working time in salaried positions to do some private psychiatry out of regular hours. This has the advantage of keeping psychiatry from separating rigidly into private and public sectors. It is to be hoped that such a dichotomy will soon disappear entirely and that future health insurance plans will make it possible for all qualified psychiatrists to make their maximum contribution regardless of their attachments. Certainly all psychiatrists able to do consultation should be available as consultants.

(f) *Social Work*

Recent trends in psychiatric care point in future to less treatment in an institution and more in the community. This will require more workers able to help patients and their families to adjust to psychiatric handicaps; it will also mean more assistance in returning patients to community life and occupation.

The training and experience of the psychiatric social worker should equip her to take more responsibility in the organization of such community services, and it should also prepare her to supervise those who might take part in such an organization, but who have had less experience in the field of psychiatry.

How many qualified psychiatric social workers were available in the Province of Quebec in 1962? According to information from the Department of National Health and Welfare, of 692 qualified social workers, 79 had experience in psychiatry and were employed in that field. Of these, 16 were working in mental hospitals, 35 in psychiatric units in general hospitals, and 17 in mental health clinics. Six others were employed in schools and three were working in programs for disturbed children.

Not only will many more psychiatric social workers be needed in this Province, but also if psychiatric social workers are to make their maximum contribution, their efforts should not be confined to case work. Those able to

administer and teach should be used in organizing and supervising those whose regular duties bring them in contact with the mentally disordered. In-service mental health training is needed for public health nurses, school teachers, and for those social welfare workers not specifically engaged in psychiatry.

7. Conclusion

(i) Radical changes have taken place in psychiatry in the Province of Quebec during the years 1961-1964; most of this study is based on the 1962 situation, but wherever possible, impending changes have been indicated.

(ii) The organization of psychiatry in the Province of Quebec differs markedly from that in the rest of Canada, chiefly because of the language situation, and because in the past most Quebec institutions have been operated by religious orders.

(iii) Before 1960, changes in psychiatric organization in the Province of Quebec, for the most part, came slowly; nevertheless, several centers in the City of Montreal have for many years rejected this conservatism, and have been in the forefront of psychiatric development in Canada.

(iv) Much of the inspiration and direction for the recent changes in psychiatry in the Province of Quebec have come from the 1961 report of a three-man Commission *Commission d'étude des hôpitaux psychiatriques*. All three members of this Commission have since accepted major responsibility in the Government's administrative organization for psychiatric services.

REFERENCES

(1) Dominion Bureau of Statistics, *Mental Health Statistics, 1961.*
(2) Bédard, D., M.D., Lazure, D., M.D., and Roberts, C.A., M.D., *Rapport de la Commission d'étude des hôpitaux psychiatriques,* March 1962.
(3) *The Quebec Mental Health Association,* brief presented to the Royal Commission on Health Services, April 1962.
(4) Prospectus, Institut Doréa.
(5) *Annual Report,* The Verdun Protestant Hospital, 1962.
(6) *The Association of Hospital Administrators,* brief presented to the Royal Commission on Health Services, Quebec, April 1962.
(7) *The Association of French-speaking Doctors in Canada,* brief presented to the Royal Commission on Health Services, March 1962.
(8) *Canadian Medical Association, Quebec Division,* brief presented to the Royal Commission on Health Services, Montreal, 1962.
(9) Lapointe, Jean L., M.D., *Child Psychiatry Across Canada: An Outline of Current Facilities and Resources,* Canadian Psychiatric Association Journal, October 1961, p. 241.
(10) Bill 39, Legislative Assembly of Quebec, 1963.
(11) Personal Communication, Dorgan, Jean, November 15, 1962.

CHAPTER 7

TRENDS IN PSYCHIATRY IN ONTARIO

1. Introduction (1) (2) (3) (4)

Just as modern art retains vestiges of Raphael, Titian, Cezanne, and all other artists who have gone before, so the psychiatric program of a province reflects the contribution of the psychiatrists of former years. Of all provinces, Ontario is the richest in psychiatric tradition; the Ontario Hospital, Toronto (999 Queen Street, West), still treats its patients in the great stone structure built in 1841 as Ontario's first Asylum for the Insane. The Ontario Hospitals at Hamilton and London still show evidence of the genius of Dr. R. M. Bucke (the Osler of Canadian Psychiatry) who, at the end of the last century, developed both of these institutions. Others who built the foundations of today's traditions include C. K. Clarke, who planned Toronto's Psychiatric Hospital, and C. B. Farrar who made it work. Between the World Wars, there was Dr. B. T. McGhie who established an administrative structure for Ontario's mental hospitals, creating a model copied by several other provinces.

Such revered traditions, however, handicap as well as help today's administrators as they try to modernize Ontario's psychiatric services. To understand the problems faced by the present director, Dr. Burdette McNeel, and by those who help him guide government-operated psychiatry in Ontario today, I shall describe the facilities for in-patient care, community care, and discuss such special topics as trends in child psychiatry, care of the aged, rehabilitation, alcoholism, and other items of psychiatric interest.

2. Mental Hospitals (1)

The Minister of Health and Hospitals, through the Chief of the Mental Health Branch, administers Ontario's mental institutions. Located near the Provincial Parliament Buildings, the Central Office includes a Hospital and a Community Mental Health Division—each with its own Director. It also has consultants in psychology, social work, occupational therapy, and a medical statistician.

The Branch staff operates 20 institutions, 6 of which deal with the mentally retarded. Ten of the remaining 14 are regional mental hospitals—each serving a group of adjoining counties. The other 4 include (1) an institution for the criminally insane at Penetanguishene (which also functions as the regional hospital for the area), (2) the Toronto Psychiatric Hospital—the University teaching center, (3) the Research and Treatment Center for Emotionally

Disturbed Children at Thistletown, and (4) an institution at Woodstock which contains 550 epileptics and 662 mentally disordered people with tuberculosis.

These 20 provincial institutions for the mentally disordered have 20,938 patients in residence, and provide most, but not all, of the Province's in-patient psychiatric service. The other places with mental hospital beds include (a) psychiatric units in general hospitals which will be described later, (b) a regional mental hospital recently opened in a former TB sanatorium in the City of Ottawa, (c) two 300-bed regional mental hospitals now being built at Goderich and Owen Sound respectively. There are also 8 private institutions (financed through the Ontario Hospital Services Commission) with a total of 455 beds.

Including the hospital schools for the mentally retarded, Ontario spent $47,916,739 in 1961 to look after the 20,000 patients in its institutions; this compared with $216,194,000 which the Ontario Hospital Services Commission paid out to operate the 34,000 beds in Ontario's general hospitals. The disparity between the two becomes more marked when one notes that the mental hospital total includes all that these hospitals have to pay for medical services, whereas the doctors' fees are not included in the general hospital budget.

Of 7,409 physicians active in the Province in 1960, more than 300 were working with mental patients; 230 of these were employed with the Department of Health. Obviously, the 230 are not able to treat the 20,938 in-patients (in addition to treating many thousands of out-patients) and, at the same time, to act as consultants to Ontario's 7,000 physicians. The question is whether Ontario merely needs more physicians specializing in psychiatry, or must also reorganize its services for diagnosing and treating the mentally disordered.

The 5,500 ward staff who look after the 20,000 patients include 637 Registered Nurses. Three of Ontario's mental hospitals have training programs whose graduates become R.N.'s after a short training period in a general hospital school; thirteen of the psychiatric institutions provide three-month affiliation to undergraduate nurses from the general hospitals (at the present time 75 per cent of the undergraduates in the nursing schools of the Ontario general hospitals receive this affiliation). With future trends pointing towards more psychiatric diagnosis and treatment being carried out in general hospitals, it seems likely Ontario will provide more psychiatric training for its undergraduate nursing students, and much more opportunity for post-graduate training in psychiatry.

The 138 social workers in Ontario's psychiatric institutions are not sufficiently numerous to cope with the rehabilitation problems of all discharged patients; nor are the 38 registered occupational therapists able to meet the demands to prepare patients for occupation after discharge—let alone do the other duties that occupational therapists are asked to do. The 88 psychologists are usually occupied, meeting requests for psychological tests in the hospitals and clinics, and so lack enough time to carry out the additional research needed (both operational and basic) and to make their maximum contribution to planning and evaluation.

Some interesting trends are developing in Ontario institutions as a result of the growing recognition as to whom the 20,935 residents include. For it is apparent that, in addition to giving treatment to the acutely sick, all institutions are providing some domiciliary service for handicapped patients with no suitable homes to go to. Recognizing this, some hospitals separate from the acutely sick those patients who, under optimum arrangements, could be cared for elsewhere.

Because the mental hospitals are large (averaging more than 1,000 patients each) and often isolated geographically, they experience some difficulty keeping in contact with the public they serve and with the general hospitals in the district. The need for such contact is generally recognized, but there is no agreement as to how it can be sustained. To help meet this problem, most authorities in Ontario recommend that no more hospitals as large as 1,000 beds be built; that additional psychiatric beds be placed either in general hospitals or in small community mental hospitals such as the 300-bed facilities at Goderich and Owen Sound, and the smaller one in Ottawa. One Ontario Hospital Superintendent is considering a plan to add obstetrical, medical and other general hospital services to his unit, so that he may serve the physically ill in an area which has limited general hospital facilities, and an increasing population.

Ontario institutions have recently shown marked trends towards increased admission and increased discharges. Of the 7,710 patients admitted in 1960, 59 per cent were discharged within 12 months. During the same period, the number of discharges from Ontario institutions totalled 75 per cent of the admissions, leaving less than 25 per cent of the admissions to be accounted for by increasing hospital population and by death. In its operation of boarding-out programs, Ontario always led the other Canadian provinces; at present there are 1,285 patients boarded out in 255 Ontario homes.

One gets the impression that much time, money and thought is expended in Ontario providing the best available care and treatment for the 20,000 in-patients; yet unfortunately, because of Ontario's larger investment in plant than any other province, and its more strongly entrenched traditions, those who are responsible for its psychiatric service are more likely to encounter serious difficulties in making radical change.

3. Mental Retardation (5)

There are six provincially run institutions dealing with the mentally retarded, plus 102 patients in two privately run hospitals. The six include (1) the original institution at Orillia, which now has more than 2,500 patients, (2) one at Smiths Falls with nearly 2,000, (3) a new institution at Cedar Springs to house 1,200, (4) two smaller units—one at Aurora with 254 retarded boys and the other at Cobourg with 485 retarded girls, (5) the Children's Psychiatric Research Institute of 70 beds which was opened in 1960 in London. The unit at London was established as a teaching and research center; in addition to short-term training, its staff provides skilled observation and treatment for the physical and emotional disorders that so often accompany mental retardation.

In addition to the 6,000 patients in the six institutions established especially for the mentally retarded, it is estimated that there are more than 4,000 retarded patients scattered throughout the 14 hospitals for the mentally ill.

The activities and interests of the Ontario Association for Retarded Children illustrate the trends in care of mental defectives in Ontario. The Association has already sponsored 74 day schools having a total of 2,300 retarded children between the ages of five and eighteen. Most of the operating funds for these are privately raised, but the Department of Education pays $300 a year for each half-day pupil, and $550 a year for each full-time pupil.

The needs of the retarded have been carefully considered by the Executive of the Association and by interested consultants. They press for the formation of

a Government body representing the Departments of Health, Education, Welfare, Reform and Labour in both the Provincial and Federal Governments. The leaders in the Association for Retarded Children believe that such a directorate with adequate funds could solve some of the most serious problems in the field.

How big is the problem of mental retardation compared to other health problems? A partial answer came from a recent sickness survey in British Columbia which showed that 18 per cent of all severely handicapped children suffer from mental retardation, more than twice as many as the next largest group identified. To meet the needs of the mentally handicapped in the community, the Executive of the Ontario Association for Retarded Children recommends increased diagnostic services with specially trained counsellors to help with home care.

Besides specially trained people who restrict their activities to dealing with the mentally retarded, the Association wants more training for teachers, public health nurses, and physicians in dealing with mental deficiency. It is also pressing for (a) smaller residential centers scattered through the Province in lieu of big institutions, and (b) for sheltered workshops to aid in the rehabilitation of retarded adults. With an eye to the future, it is also asking for increased funds for research.

4. Community Services (6)

Through its Community Mental Health Branch of the Department of Health, the Province administers 25 full-time Mental Health Clinics. Twelve of these are actually located in Ontario Hospitals; three of the remainder are in general hospitals, even though administered by the Province. Three of the Provincial Mental Health Clinics are exclusively for children, and one (at the Toronto Psychiatric Hospital) is a forensic clinic. Seven of the 25 clinics have travelling teams, which visit a total of 19 centers to provide consultation services for local family doctors and social agencies.

Of 16,802 patients seen in the Provincial clinics in 1961, 9,700 came for the first time. Forty-two per cent of all patients seen were children, and 30 per cent of the referrals came from family doctors.

In addition to the 25 clinics operated by the Province, there are 9 full-time clinics under local auspices. These are run by municipalities, by general hospitals and by private agencies, and in 1961 dealt with more than 10,000 patients. Although these clinics are under the local authorities, most are supported by Provincial grants—often through funds from the National Health Grants.

The Province has set itself an objective of one clinic for each 100,000 population, and, including the locally operated clinics, it already has reached about two-thirds of the total it thinks it needs.

In both Government- and locally-sponsored clinics, Ontario follows a pattern established more than 30 years ago. Perhaps some features of this pattern are now obsolete. The clinics were first set up to provide free services for those unable to pay; thirty years ago it was almost impossible to find any qualified psychiatric consultants outside of mental hospital. With an increase in private practice in psychiatry, with recently graduated family doctors now having had much more psychiatric training, and with an increasing number of persons being covered by medical care insurance, the old free Government clinic may no longer

be as necessary as it once was. Psychiatry has always suffered by being different from the rest of medicine, and it would be advisable to provide psychiatric services on the same basis as medical and surgical services. Due to a shortage of personnel and other factors, the goal of equal acceptance of psychiatry has not yet been reached, but is becoming more attainable.

Future trends will result in much less difference between the operation of the private psychiatrist and other physicians specializing in psychiatry. This distinction will become less necessary if Ontario introduces the system of financing medical care which has recently been proposed—as long as psychiatry is included.

The Province of Ontario has developed day care in four centers, at the Ontario Hospitals at New Toronto, at Woodstock, at Cobourg, and at the Toronto Psychiatric Hospital. As this type of community service is extended the need for more hospital construction will diminish.

5. Psychiatry in General Medical Services

(a) *General Hospitals* (1)

Ontario has 212 general hospitals of which 190 are for acute patients, 6 for convalescent, and 16 for chronic. In 1961, the acute service had 28,738 beds—about 5 per 1,000 population. Together with 525 convalescent and 5,126 chronic beds, there is a total of 34,589 general hospital beds in the Province of Ontario. In addition to general hospitals, there are 55 private hospitals with 1,472 patients.

In 17 of the 212 general hospitals, there are psychiatric units containing a total of 538 beds. These units are operated by the Boards of the General Hospitals, but all have grant assistance from the Province and from the Federal Government. A hospital which builds a psychiatric unit may receive $8,500 per bed from the Province, and $2,500 from the Federal Government. The operation of all psychiatric units in general hospitals is financed through the Hospital Service Commission.

The 17 units had about 3,000 first admissions in 1961, which is slightly more than a third of all the first admissions to in-patient psychiatric facilities in Ontario. The patients stayed in hospital for an average of 22 days; 90 per cent were discharged home, with 10 per cent being ultimately transferred to a mental hospital.

In addition to the 17 psychiatric units in general hospitals, there are another 23 general hospitals which have two or three beds for the care of disturbed psychiatric patients pending their transfer to mental hospital; there is a total of 41 beds for this purpose.

Is the trend in Ontario towards more units in general hospitals or towards an extension of the Government-operated mental hospital services? At the moment, attention is focused on the three Community Mental Hospitals now being established at Goderich, Owen Sound and in Ottawa. These present a third alternative which is in between the two mentioned above. The trend away from the big mental hospital is confirmed in Ontario; in 1960, the trend seemed to be moving towards community hospitals of 300 to 400 beds—although some thought these institutions would perpetuate the separation of psychiatry from general

hospitals. However, two years later this trend seemed to have changed towards an expansion of psychiatric beds in general hospitals; this is of interest in view of the experience in Manchester and elsewhere which has shown that, given enough general hospital beds and good community services, it is possible to look after all of the patients in a community without a large mental hospital. To achieve this, the requirements may be less than one bed per 1,000 for acute patients, plus .3 to .4 beds per 1,000 for chronics. Even though this pattern of caring for all psychotics in general hospitals and in the community is possible, admittedly, it does not mean that it is necessarily better than using big or small mental hospitals. Projects should be set up in Ontario to compare the three different patterns of care, namely (1) the big mental hospital, (2) the small community mental hospital, (3) a psychiatric unit in general hospital with comprehensive community services, but with no mental hospital associated. Such pilot projects with good evaluation would yield most useful information.

(b) *General Practitioners* (2) (9)

With 7,409 physicians registered in the Province in 1960, Ontario has a ratio of one doctor for 780 population, giving it the second highest ratio in Canada—which has one to 839 population. There is one general practitioner to each 1,254 population which compares with one psychiatrist to 28,048.

The Ontario Division of the College of General Practice (which was founded in 1954) has taken the lead in emphasizing the importance of psychiatry to general practitioners. Along with the Canadian Medical Association the Ontario Division of the College of General Practice calls for a better integration of psychiatry with the rest of medicine. A CMA statement suggests that "the large mental hospital is as outdated as thigh operations without anaesthesia". Obviously the rank and file of general practitioners do not yet share the enthusiasm for psychiatry which their official representatives have voiced. Nonetheless, it is becoming clear that most of the depressed, confused and anxious people who receive care and attention get it from their family doctors rather than from psychiatrists. There are just not enough psychiatrists and, moreover, most patients—regardless of the origin of their illness—want to be treated by their own doctor.

6. Public Health (4)

As in other provinces, the Provincial Department of Public Health in Ontario is concerned with prevention rather than service. This staff of doctors, sanitary engineers, statisticians, health educators and public health nurses work on the principle of applying scientific knowledge to the prevention of disease.

In such a department, however, psychiatry remains essentially a problem of providing service—too little is known about the etiology of mental illness to launch as yet an effective program of prevention. Like most other provinces, Ontario has placed the responsibility for the care and treatment of its mentally disordered in the Department of Health; this was done because this responsibility had been rejected by the rest of medicine. Public Health acquired psychiatry by default and has not been happy about this acquisition. The question now becomes whether psychiatric services should remain the responsibility of the Public Health Departments, and, if so, what has Public Health to contribute? Thirty years ago the mental hospitals of most provinces were not in the Departments of Public Health; more often they came under the Public Works

Department or under the Provincial Secretary. The trend to place these hospitals in Departments of Public Health was greeted enthusiastically by many as a step towards recognizing mental disorder as an illness, and hence better integration of psychiatry into medicine; unfortunately, Public Health Departments, as such, have done little to further this integration. Psychiatry has not even made use of the one principle that Public Health has applied so effectively—namely scientific evaluation of the results of a planned program; here is something that psychiatry needs badly.

The outstanding contribution of Public Health to psychiatry has been the use of public health nurses to follow up discharged mental patients. The Province of Ontario has one such program centered at the Ontario Hospital, St. Thomas. Under the guidance of a psychiatric social worker, the public health nurses of some of the County health units in the St. Thomas Mental Hospital region follow-up patients discharged from the mental hospital; they do this with the co-operation of the local family physician.

Meanwhile, the question is raised as to whether psychiatry should be removed from the administration of the Department of Public Health and be organized like the rest of medicine. Should not the psychiatric beds be under the administration of local hospital boards, and should not the hospital care of the mentally sick be in the same building as the care of the physically ill and financed through Federal and Provincial Hospital Programs? The principle of using local Boards is being followed in Ontario with the Community Mental Hospital.

7. Voluntary Associations

(a) *Ontario Division of the Canadian Mental Health Association* (2)

The Ontario Division of the Canadian Mental Health Association has 19 branches and 6,200 members. It is one of nine Provincial divisions of a National body—founded by Dr. C. M. Hincks in 1919 under the original name of the National Committee for Mental Hygiene (Canada). The Ontario Division, in accord with the policy of the National Executive of the organization, stresses the need to improve mental health services by co-ordinating the efforts of those existing organizations whose work is important to mental health. These include Government Departments of Health, Education, and Welfare, also schools, churches and family physicians. The Canadian Mental Health Association also adds its voice to the chorus of those recommending more personnel for psychiatry, and more funds for research. The prime function of the Division is, of course, to educate the public and to get its active support for better mental health care. The Canadian Mental Health Association has demonstrated that without support and action of other citizens, professionals cannot provide good psychiatric services. The problem of the organization is how to convince the public of the great needs facing psychiatry without emphasizing the differences between psychiatry and the rest of medicine.

(b) *Ontario Association for Retarded Children* (5)

During the discussion of Ontario's program for helping the mentally retarded, I have already referred to the goals of this Association. It was founded ten years ago by the relatives of the retarded; they were dissatisfied with the help provided by the State for mentally retarded children, and, through their own efforts, set out to bring about a better program. In this they have been very

successful. There are now 78 local branches in Ontario with 7,000 members, and 2,300 children in 74 schools.

The Association wants improved services; it is also asking for funds for more personnel, for counsellors for parents, for sheltered workshops for the adult retarded, and for small decentralized residences for those who need accommodation. They have also recommended two more units similar to the Children's Psychiatric Research Center now at London, Ontario. The Association stresses the need for funds for research, and for the training of public health nurses and teachers.

(c) *The Ontario Association for Emotionally Disturbed Children*

This small group has been formed by the parents of autistic children. The goal is to have more research on the cause and treatment of emotional disturbances in children, and to have much more done about providing treatment facilities.

8. Special Areas

(a) *Child Psychiatry* (7) (8)

Most of the 35 Government and private Mental Health Clinics provide some service for children; at least four are entirely restricted to children. Forty-two per cent of all patients seen in Ontario's mental health clinics are under the age of 18.

At Thistletown near Toronto, the Provincial Government operates a 65-bed Research and Treatment Center for emotionally disturbed children. Here children with severe emotional problems may receive in-patient treatment lasting up to 18 months.

Adding the beds at Thistletown to beds set aside in some paediatric departments, there are about 150 beds in Ontario for emotionally disturbed children, and it is estimated that at least 2,000 of Ontario's 22,000 psychiatric beds should be for this purpose. There is a need for accommodation in day-care centers for an additional 1,000 disturbed children. The agencies now seeking help are primarily the schools, juvenile courts and social welfare centers. As elsewhere, there is much talk in Ontario about the need for facilities to treat the emotionally disturbed child, but no agreement as to the sort of services that should be provided. Of all provinces, Ontario would be the ideal site for a variety of pilot projects to explore different ways to provide help for mentally disordered children.

(b) *The Aged*

As in other provinces, the care of the mentally-ill aged presents Ontario with its most difficult psychiatric problem. Nearly 600,000 Ontario residents are over 65, and if Roth's Newcastle estimate is correct, more than 50,000 of these present psychotic symptoms. Actually, the Ontario Hospitals now house approximately 7,000 patients over 65. Many of the 7,000 (probably 50 per cent) even though handicapped by mental disorder, could be cared for elsewhere (including at home)—if the community had a place for them. In other words, the mental hospitals in Ontario are providing domiciliary care for more than 3,000 old people who should be somewhere else.

Ontario's record on domiciliary care for old people is generally good. There are 117 municipal homes for the aged, which house a total of 7,400 old people. These are patients who do not normally require the services of physicians and registered nurses even though many of them may be bed patients due to the aging process. For their care, the Province (with Federal support) pays 50 per cent of construction cost, and 70 per cent of operational costs. At present, the per diem cost runs about $3.63, although critics suggest this should be increased to about $5.00. The supervision of these municipal homes, on behalf of the Provincial Government, is carried out through the Department of Social Welfare; these authorities recommend that, ideally, these homes should contain between 100 and 250 beds. The policy of this Department quite properly makes it very clear that these institutions are substitute residences for those without homes —not chronic hospitals.

Besides the municipal homes for the aged, there are 56 homes, with a total of 4,192 beds, operated by charitable organizations. This gives Ontario more than 11,000 domiciliary beds for its old people. It is estimated that the needs of homes for the aged runs at about 2 per cent of the total population, which, in Ontario, would be 12,000; obviously this would not be enough if the 3,000 domiciliary patients now in mental hospitals are also to be accommodated.

A much greater problem than domiciliary care is the need for beds for the chronically ill old. Where chronic beds exist, the Ontario Hospital Services Commission now pays the operating expenses. For the old people with chronic physical illness, the estimated need is one bed per 1,000 which would total about 6,000 beds. At the present time Ontario has about 5,000 beds for chronic illness. Unfortunately much of this accommodation is not adjacent to the acute hospital services, so it is difficult for the chronically sick patients to get the medical and nursing help they need. Furthermore, as a matter of policy, the mentally ill aged are not now admitted to beds for the chronically ill. There are obviously a number of mentally ill patients who are too sick for their own homes or for homes for the aged, yet will not recover in the 20 to 30 days which are usually required in acute psychiatric units. These patients include some severely retarded individuals, a few schizophrenics—mostly paranoid, and a much larger number of brain-damaged old people. Rather than continuing to segregate in isolated mental hospitals the sick old people who need a good deal of skilled care by physicians and nurses, it would seem wiser to consider including these brain-damaged patients with other chronic sick in wings attached to acute general hospitals. Besides providing the best possible combination of medical and psychiatric care, this would locate the patients near their homes. It would also give the hospital's visiting general practitioners a chance to learn to diagnose and treat mental illness due to senility—a common problem in general practice.

If the chronic mentally ill were to be included, how many chronic beds would be needed in general hospitals in addition to the one bed per 1,000 required for chronic physical illness? It is estimated that about .3 beds per 1,000 are needed for brain-damaged old people. There is, however, much overlapping between the brain-damaged aged and other chronic sick. It is probable that 1.2 beds per 1,000 would more than take care of all the chronically ill in need of the intensive medical and nursing care of the general hospital. Such an arrangement would result in confused old people receiving much more skilled attention from competent internists than is now possible in the isolated mental hospitals.

(c) *Rehabilitation*

The greatest lack in psychiatric service in Ontario (as elsewhere) is in psychiatric rehabilitation. Rehabilitation has been defined as providing the individual with the greatest independence compatible with his handicap; even slight residual handicaps bar many patients discharged from mental hospital from returning to a useful and rewarding life in the community. Part of this impediment is due to the stigma carried by mental disorder, and part is due to an absence of adequate facilities in the community to rehabilitate mental patients.

Originally, the return of the mental patient to the community (and hopefully to his job) was arranged by the hospital psychiatrist through visiting relatives; often when the patient left the hospital that was the last the staff heard of him. Ontario was one of the first provinces to set up travelling clinics with psychiatrists and nurses who saw discharged patients near their own homes and helped work out rehabilitation problems. More recently, at least one of the Ontario Hospitals (St. Thomas) has started to make use of the public health nurses of county health units to follow up discharged patients. More of this could be done with more use being made of field personnel in Provincial and Federal Departments of Health, Education, and Welfare, with more field staff being added. It is estimated that the present number of psychiatric beds (four per 1,000) in Ontario could be kept to less than two per 1,000 with more treatment of the mentally disordered in the community. This will not be possible without the help of a much greater number of professional people in the community working on mental health problems. Public health nurses, social workers, family doctors, and other community workers need to have more psychiatric knowledge and to accept more responsibility for discharged mental patients; psychiatrists must also provide these community workers with much more support and supervision.

Ontario receives grants-in-aid from the Federal Government for the training of professional personnel for medical rehabilitation (this grant also can be used for buying equipment). So far, little use has been made of these grants to improve psychiatric rehabilitation.

(d) *Alcoholism* (10) (11)

Ontario leads the country (and possibly the world) in its services for the diagnosis and treatment of alcoholics. Ontario has had a long-time interest in the problems of alcohol as demonstrated by its early experiments with prohibition. In 1875, the present Ontario Hospital at Hamilton was opened as an institution to treat alcoholics (few appeared, so it became a regional mental hospital). It is estimated that Ontario now has 100,000 alcoholics, about 10,000 of whom are members of Alcoholics Anonymous.

The keystone of service for alcoholism in Ontario is the Alcoholism and Drug Addiction Research Foundation which was originally founded as the Alcoholism Research Foundation in 1951. Most of its budget comes from Provincial funds which accounted for $1,065,000 in 1962-63. The present goal is to provide research and education with a certain amount of service. The Foundation is centered in Toronto, but there are three branches (London, Hamilton and Ottawa). It has 13 beds in Toronto in which patients remain an average of 23.2 days; it also has an active day-care center.

The Board of the Foundation plans to restrict the service activities to include a total of not more than 10 per cent of those in the Province needing diagnosis and treatment. The Board hopes to locate branches throughout the Province and

at these branches will provide exemplary service; the branch will furnish consultation and education services to other organizations and individuals who, in turn, will then provide the bulk of direct service for those suffering from alcoholism. Other agencies in Ontario providing service for alcoholics include the Ontario Hospitals, the Reform Institutions, the Salvation Army, Alcoholics Anonymous, medical practitioners and general hospitals; of all these, the general hospitals are most resistant to the alcoholics' need for help. Certainly, something must be done to have the general hospitals participate more in the program, as this would provide doctors and nurses with much useful instruction. Future trends in Ontario will certainly be towards the Alcoholism and Drug Addiction Research Foundation setting up more demonstration units and more satellite units, thus involving more people in the treatment of the alcoholic.

(e) *Forensic Psychiatry* (12)

The Toronto Psychiatric Hospital maintains a forensic clinic, which in 1961 examined 337 new patients; 76 per cent of these were referred because of sex problems. The clinic was the happy outcome of a wave of hysterical fear generated by a rash of sex crimes in Toronto in the mid-1950's. The clinic endeavours to provide diagnosis, consultation and treatment for court referrals, and to carry out teaching and research.

(f) *Legislation*

The enabling legislation for mental health programs in Ontario includes the Mental Hospitals Act, the Children's Mental Hospitals Act and the Community Psychiatric Hospitals Act. Thanks, in great part, to the efforts of one man, Dr. K. G. Gray, who is both a lawyer and a psychiatrist, Ontario has usually taken the lead in creating progressive legislation over the last 30 years; recently it may have been temporarily left behind by new legislation passed in Great Britain and in Saskatchewan.

The so-called criminally insane are usually lodged in the Ontario Hospital at Penetanguishene; this makes it possible for the other Ontario Hospitals to avoid locking doors due to legal responsibility for patients held in Lieutenant-Governor's warrants. Unfortunately, not all Ontario Hospitals take advantage of this opportunity.

The Reform Institutions have shown interest in developing psychiatric and psychological services for the treatment of psychopaths, and other mentally disordered people under sentences, but they could do much more.

(g) *Research*

Although psychiatric research in Canada is generally decried as meagre, Ontario contributes more research than most. There are the research programs in the four university departments of psychiatry. In addition to the research centers (the Children's Psychiatric Research Unit at London, and the Research and Treatment Center for Emotionally Disturbed Children at Thistletown) there are several research projects in the Ontario Hospitals. Recently, a mental health foundation was set up in Ontario to receive donations for research. Ontario also supports the research interests of the Canadian Mental Health Association and the Association for Retarded Children.

The needs of research have been clearly annunciated and emphatically stated. These include funds to increase the tempo of research in the social

sciences, in the basic sciences related to psychiatry, and in treatment techniques. The Canadian Mental Health Association has stressed the need for closer co-operation between the research institutions and the clinical centers, and for the provision of full-time research posts rather than continuing the insecurity created by a policy of grants-in-aid.

Since funds available for research in psychiatry in Canada approximate only 15 per cent of the total funds available for research in physical medicine (in proportion to the cost of services) there have been several demands for an eightfold increase in the money earmarked for psychiatric research.

Most critics of research support proponents for research institutes, although the trend towards such institutes is viewed with apprehension by some.

(h) *Private Psychiatry*

There are about 85 psychiatrists in Ontario who earn their living chiefly through private practice; many of these have part-time appointments in municipal clinics or act as consultants to agencies. There are a number of salaried psychiatrists who also do some private practice.

In contrast to private practice in other medical specialties, private practice in psychiatry was hampered for many years by the prejudices of fee-paying agencies. Recently the situation has improved, and both those who draw up Ontario's fee schedules and the paying agencies have tried to do better by the mentally ill. Some of the local paying agencies now pay $25.00 for the first consultation, $5.00 a hospital visit up to four weeks (with a maximum of $15.00 a week after four weeks), $5.00 for each electroconvulsive treatment, $10.00 an office visit for psychotherapy up to two months, with restrictions to two treatments a week after two months, and two treatments a month after six months.

The future of private psychiatry in Ontario will, of course, depend in large part on the future of medical practice in that Province. There is much agitation to increase the private practice rights of salaried psychiatrists, or at least to have the private practitioners of psychiatry and the Government psychiatrists share similar patterns of work and pay.

(i) *Psychologists* (13)

There are 650 individuals in Ontario who earn their living in the field of psychology—400 of whom have M.A.'s or Ph.D.'s. In Ontario, 35 years ago, most psychologists began as psychometicians in the Province's Mental Health Clinics, and in the Ontario Hospital School at Orillia. Now many psychologists are engaged in university teaching, research, therapy and industrial consulting. About 40 per cent are still located in the Provincial Hospital Service.

Recently, the Canadian Psychological Association set up standards requiring registration for certain tasks. To be registered, a psychologist must have a Ph.D. or an M.A. and other fixed qualifications. There is some restriction in administering therapy as far as the need for medical supervision is concerned.

(j) *Medical Education*

The four departments of psychiatry in the four medical schools carry out active undergraduate and graduate programs. At present, regulations of the Royal College require that graduates presenting themselves for certification or

fellowship examinations in psychiatry must have four years of approved training, at least two of which must be under the immediate direction of a medical school. Some training funds are now procured from the Departments of Public Health, and through it from the National Health grants. If recruitment of psychiatry is to be increased, more Provincial and Federal support will be needed.

9. Conclusion

The highlights in the survey of trends in psychiatric care in Ontario can be summarized as follows:

(i) Ontario has the oldest and richest tradition in psychiatry of any province in Canada; this presents some disadvantage in making radical change.

(ii) With 20 institutions, Ontario has by far the largest investment in plant of any province. It also was the first Province to experiment with the 300-bed Community Psychiatric Hospitals.

(iii) With 34 full-time mental health clinics (25 provincially operated), Ontario has the most complete community coverage of any province in Canada.

(iv) All of 17 psychiatric units in general hospitals are under local, rather than Provincial management; they supplement rather than substitute for the Provincial mental hospitals.

(v) Ontario's program for alcoholics is better organized and better financed than any program in any comparable area anywhere, and has evolved an interesting modification of the principle of using central funds to stimulate local effort.

REFERENCES

(1) 94th Annual Report, Mental Health Branch of the Department of Health of the Province of Ontario, 1960.
(2) *The Ontario Division, Canadian Mental Health Association,* brief presented to the Royal Commission on Health Services, May 1962.
(3) Submission of the Province of Ontario to the Royal Commission on Health Services, August 1962.
(4) *The Canadian Public Health Association,* brief presented to the Royal Commission on Health Services, Toronto, April 1962.
(5) *The Ontario Association for Retarded Children,* brief presented to the Royal Commission on Health Services, May 1962.
(6) *Ontario Psychiatric Association,* brief presented to the Royal Commission on Health Services, April 1962.
(7) *The Children's Mental Hospitals Act,* Ottawa: Queen's Printer, 1961.
(8) *The Ontario Association for Emotionally Disturbed Children,* brief presented to the Royal Commission on Health Services, Toronto, May 23, 1962.
(9) *The Ontario Medical Association,* brief presented to the Royal Commission on Health Services, Toronto, May 1962.
(10) Alcoholism Research Foundation, Ninth Annual Report for the year ending December 31, 1959.
(11) Alcoholism Research Foundation, Tenth Annual Report for the year ending December 31, 1960.
(12) Fourth Annual Report, Forensic Clinic, Toronto, 1961.
(13) *The Ontario Psychological Association,* brief presented to the Royal Commission on Health Services, August 1962.

CHAPTER 8

TRENDS IN PSYCHIATRIC CARE IN MANITOBA

1. Introduction

In building up services for the mentally disordered, the people of the Province of Manitoba have displayed the same vigor and progressive spirit that they have so often shown in other community activities. Manitoba's success in psychiatry should be no less spectacular than in the arts, where, from its mixed ethnic population, it has produced some of Canada's best artists in the fields of music and drama. Although handicapped by sparsely populated areas, spread out at considerable distance from the one big city housing most of its medical specialists, Manitoba bids fair to develop a program of psychiatric care well ahead of anything else in Canada.

Manitoba has had exceptionally good leadership in the field of psychiatry. Less inclined than psychiatrists in some other provinces to devote time to national psychiatric organizations, Manitoba psychiatrists have put much time and effort into solving Provincial psychiatric problems; the results make this clear. Co-operation between Government officials and university teachers is as good or better in Manitoba than in any other province. Some of this co-operation is attributable to a former Director of Mental Services, Dr. T. A. Pincock, but the tradition has carried on well under the present Director of Mental Services, Dr. E. Johnson, with the close co-operation of the Professor of Psychiatry, Dr. George Sisler.

Only British Columbia has a similar problem of organizing psychiatric services in a large area dominated by one city containing half of the Province's population. Greater Winnipeg has 467,000 of Manitoba's more than 900,000 people. It is located at the south-east angle of Manitoba's fertile triangle, which contains more than 90 per cent of the population in less than 30 per cent of the Province's area. Also in the same area, Brandon, with a population of 27,000, and Portage la Prairie, with 12,000, are the only other Manitoba centers with more than 10,000 people. Located some distance from half of the Province's population, Winnipeg has most of the psychiatric resources. This poses two quite different problems: (a) providing psychiatric services for a city of 500,000, and (b) providing regular services for another 500,000 people scattered over 250,000 square miles.

2. Mental Hospital Services (1)

The mental hospitals in Manitoba come under the direction of the Provincial Psychiatrist who, until recently, also doubled as the Director of the Winnipeg

Psychiatric Institute; with the prospect of much of the Director's future time being spent supervising major changes in the psychiatric services, the Government has made the Provincial directorship a full-time post.

Located in the Department of Public Health, the Division of Psychiatry has a budget of $5,500,000—a major item in a Health Department budget of $12,295,000, and in the Provincial budget of $111,000,000. A total of $357,123 of the Mental Health Division budget comes from National Health Grants, which help a great deal in setting up new services, and in conducting educational programs. As elsewhere, the per diem cost in Provincial mental hospitals is much lower than in general hospitals—about $4.50 a day compared to $22.00.

The Provincial institutions (as of December 1962) for the care of the mentally disordered include (a) the Selkirk Hospital for Mental Diseases, which was opened in 1886 and now has a patient population of 1,071 (down from 1,248 in 1959); (b) the Brandon Hospital for Mental Diseases, opened in 1891, now with a patient population of 1,417 (1,690 in 1959); (c) The Psychopathic Hospital (now Winnipeg Psychiatric Institute) on the grounds of the Winnipeg General Hospital, opened in 1919 with 56 patients at the present time. There is also the Manitoba School for Mentally Defective Persons at Portage la Prairie, opened in 1933, now with 1,134 patients. These four Provincial institutions have a total population of almost 3,900, making a rate of 428 per 100,000 population compared to the Canadian average of 372.

The number of patients in Manitoba's institutions has diminished during the past ten years—sometimes by as many as 150 a year. In a strongly obsolescent fashion, Manitoba still deprives its newly admitted mental patients of their right to administer their own property; even so, the number of admissions continues to rise at the rate of 10 to 15 per cent per year.

To look after their nearly 4,000 patients, the institutions have an establishment for 36 physicians, 29 of which positions are currently filled; only eight of these 29 physicians are qualified psychiatrists. Although the comparison is not quite accurate, some indication of psychiatry's manpower problem comes from the fact that 29 of the Province's 1,033 physicians have to look after nearly 4,000 of the Province's total of 8,600 patients in all its hospitals—mental and general.

In the past, to maintain and increase its mental hospital medical staff, the Province has depended in part on recruitment from overseas. To prepare nearly 20 psychiatric residents for qualification examinations, the Mental Health Division co-operates with the university's residency training program. The residents who apply for and obtain Provincial bursaries receive $550 a month for the first year; half of this stipend consists of Provincial funds paid in return for services rendered—the other half is from National Health Grant funds earmarked for education. In the second and third years, a bursary of $200—$250 a month is received, plus a stipend from the place of work. The residents are paid $8,000 a year during the fourth year. Two of these four years must be spent in a rotation through the psychiatric training centers in the City of Winnipeg. These centers include the psychiatric units in general hospitals, the Child Guidance Service, the Children's Hospital, and the psychiatric unit in the Deer Lodge Veteran's Hospital.

The ward nursing staff in the Provincial institutions consists mostly of either graduates or undergraduates from the Province's training program for licensed psychiatric nurses. In its three-year course, the hospital at Brandon has 80 students, and at Selkirk 72. The institutions also have post-graduate courses for

registered nurses seeking training in psychiatry, and for public health nurses; there is also an affiliation for students from some general hospitals.

As long as most of the confused, depressed and anxious people are treated in isolated institutions, this pattern of training nurses in mental hospitals will likely continue. If the plan to integrate psychiatric care with its general hospital services succeeds, then the training of psychiatric nurses will almost certainly merge with R.N. training.

Like most superintendents today, those in charge of Manitoba's mental hospitals have striven to modernize wards, to improve treatment facilities and to open doors. Manitoba has an exceptionally active program of rehabilitation and remotivation within its mental hospitals. The distance of the two larger institutions from the population center has impeded attempts to develop day care.

Although its hospitals have more than their share of long-term residents who could be treated elsewhere if alternative facilities existed, thanks to the large number of beds in Provincial Homes for the Aged, the problem of old people is less acute in Manitoba's mental hospitals than in some other provinces. A wide variety of homes for the aged contain more than 3,000 persons. Through the Department of Social Welfare, the Province provides 20 per cent of the operating funds for these homes—some of which are overdue for remodeling or for replacement. While, as in other provinces, the mental hospitals in Manitoba are wrongly used as homes for the aged confused people, yet the tradition of caring for some of these patients in other facilities has been well established and is expanding.

3. Community Care (1)

The present trends in the mental hospital program in Manitoba provide some clues to future developments. Many leaders in the Province's health field are looking for better methods of providing psychiatric care. Representatives from the Department of Health and from the voluntary agencies have worked out plans for developing acute facilities in general hospitals that might one day replace the acute treatment services of the mental hospitals. Nevertheless all realize that such programs could only be successful if backed up by an extension of community care. These supporting facilities would have to include enough high standard homes for the aged to accommodate all mildly confused old people who, although without homes of their own, still do not require care and treatment in a chronic hospital bed. Other medical facilities (to be described later) would also have to provide support.

As elsewhere, Manitoba's leaders in psychiatry urge a shift in the locus of treatment from the mental hospital to the community. For Winnipeg's 478,000 population, such an increase in community care seems feasible; in the remainder of the Province it would be more difficult.

Winnipeg now has four Mental Health Clinics—serving primarily adult patients. These are located at the Winnipeg Psychiatric Institute, at the St. Boniface Hospital, at the Winnipeg General Hospital, and also at the DVA Deer Lodge Hospital.

Outside Winnipeg, the mental health clinics have been centered at the Hospitals for Mental Diseases at Brandon and at Selkirk. The clinic at the

Brandon Hospital was opened in 1920, and that at the Selkirk Hospital in 1925; recently a second clinic under the guidance of the mental hospital at Selkirk has been established in the Town of Selkirk.

From the mental hospitals, travelling clinics have fanned out to provide regular visits to such centers as Dauphin, Virden, Birtle, Neepawa and Flin Flon. These travelling clinics began as follow-up services for patients discharged from mental hospital, but, as was inevitable, were soon called on to provide consultation services to physicians and agencies in the areas visited.

The trends in community service in psychiatry in Manitoba point to the need to have more skilled consultants available to non-psychiatric medical personnel in the community. Whether they like it or not, family doctors and public health nurses are called upon to help and advise people with psychiatric problems. To meet this need effectively, they must have ready access to psychiatric consultation services. This can best come from the mental health teams that the Manitoba Government is organizing, and which include a psychiatrist, a psychologist, and a welfare worker. Even though her job is mostly social work, the welfare worker of the mental health team is usually a nurse—with psychiatric experience.

4. General Medical Services

(a) *General Hospitals* (2)

Not including the Veteran's Hospital at Deer Lodge, there are 103 general hospitals in Manitoba with a total of 4,778 beds. This gives the Province a rate of 5.7 beds per 1,000 population compared to the Canadian rate of 4.9 beds. Except in Winnipeg, Brandon, Portage la Prairie, and in Selkirk, few, if any, of the general hospitals have consultant psychiatrists available. Of all the hospitals in the Province, only 12 have more than 100 beds and so could make good use of psychiatric services.

Besides the 4,778 acute beds, there are about 650 beds in chronic hospitals (apart from the mental and the tuberculosis institutions); although, as in all chronic hospitals, these hospitals for chronic physical disease contain a number of patients with psychiatric disabilities, the admission of psychiatric patients as such is not encouraged. There is considerable support for the recommendation that the number of chronic hospital beds in the Province be doubled.

In Winnipeg, experience to date with chronic beds indicates that family physicians will not visit these institutions unless situated adjacent to acute general hospitals. In the future, it would seem wise to attach all chronic care units to general hospitals. It would also seem wise to establish a policy of permitting and encouraging the admission of long-stay psychiatric patients to these units. Many patients with chronic physical illness also have chronic mental illness and *vice versa*. If the present ratio of .7 chronic beds per 1,000 was increased to 1.5 per 1,000, it seems likely that this would be sufficient to look after all the long-stay mental patients—in addition to the long-stay physically ill. Ultimately, in looking after the chronic mentally sick, such units might replace the mental hospital.

(b) *Psychiatric Units* (2)

Aside from the 60-bed psychiatric unit in the Deer Lodge DVA Hospital there are only three psychiatric units in general hospitals in Manitoba—all in

Winnipeg. These are located in three of Winnipeg's four general hospitals—the Winnipeg General (46 psychiatric beds), St. Boniface (23 psychiatric beds) and Misericordia (17 psychiatric beds). These units take in half of the total number of patients admitted to psychiatric beds in the Province of Manitoba. The patients stay an average of 21 days, which is only slightly longer than the average stay of other patients in general hospitals. The cost of care in psychiatric units runs about $22.00 a day per patient, compared to $4.50 per day in the hospitals for nervous diseases; the units are financed under the Manitoba Hospital Services Plan.

Recognizing how psychiatric units in general hospitals can break down the barriers which have existed between psychiatry and the other medical services, senior officials connected with the Manitoba Government have frequently spoken in support of psychiatric services in general hospitals. The plan put forth calls for units of from 100 to 200 beds in the Winnipeg General Hospital, in the St. Boniface Hospital, and in hospitals at Dauphin and at Portage la Prairie. How well these first three or four units come along will determine whether the same pattern is used later in other general hospitals.

A surprising amount of support for psychiatric services in general hospitals has come from the administrators of these hospitals. The Medical Director of the hospital at St. Boniface told me that he hoped to include a 100-bed unit for acute and chronic psychiatric patients in the St. Boniface building program. What these trends mean for the future depends, of course, on the success of the units planned. Many think that psychiatry will become an accepted part of general medical practice—like medicine and surgery. Perhaps, in the future, psychiatry will be decentralized and no longer the responsibility of the Department of Public Health. If the British plan was followed, these decentralized services would come under local administration, but would need to get at least 80 per cent of their operational and capital funds from Federal and Provincial sources.

Could such decentralized services ultimately replace the mental hospital? What would be involved in such a change? At present, in mental hospitals, there are nearly 3 beds per 1,000 population, plus 1.1 beds per 1,000 for the mentally retarded; to replace this would require nearly 1,000 acute psychiatric beds distributed among Manitoba's general hospitals, with access to at least 500 chronic beds in chronic care units also attached to general hospitals. The Province would also need an effective plan for community care for the mentally disordered. To what extent this transfer of psychiatric care from mental to general hospitals would be desirable and feasible could only be determined after the proposal has been tried out in carefully planned pilot projects, and the results evaluated.

(c) *Psychiatrists* (2)

There are 27 qualified psychiatrists in Manitoba—about one to each 30,000 population. The Canadian Psychiatric Association's goal of one psychiatrist to each 10,000 population is admirable, but I doubt whether it can be realized during the next 25 years; it would mean achieving a ratio three times as great as that now existing in Canada, and Manitoba is unlikely to accomplish this.

Of the 27 psychiatrists, only 8 are in Provincial service; 2 are with the Federal Government, 4 are in universities, and 13 in private practice. Many of the private practitioners of psychiatry also have part-time community jobs. As elsewhere, psychiatrists in Manitoba spend a good deal of their time providing service for individual patients; they spend much less time consulting with

non-psychiatric physicians and with social agencies. This pattern maintains the isolation of psychiatry from the rest of medicine, and raises the question whether it would not be advisable for psychiatrists to increase the time they spend in consultation, and to cut down proportionately on individual therapy. Perhaps the results would be better if psychiatrists would spend a greater proportion of their time with general practitioners and with public health nurses than they do with patients.

Compared with the psychiatrists employed by the Provincial Government, Manitoba's 13 psychiatrists in private practice spend a greater proportion of their working hours in consultation services; yet they too provide more service than consultation. The private practice of psychiatry is well recognized by the Manitoba Medical Services (the physician-sponsored fee-paying organization); it pays for most psychiatric services, including for the treatment of alcoholics and—an interesting item—"for the treatment of suicidal attempts".

(d) *Physicians* (2)

There are 1,033 physicians registered to practise in the Province of Manitoba. This makes a ratio of one doctor for each 871 population, which is just slightly better than the Canadian average. Of the 1,033 physicians, 788 practise in Winnipeg with 245 practising elsewhere in the Province. The 788 doctors in Winnipeg include all except 18 of Manitoba's 351 qualified specialists; the non-specialists are divided more evenly between the Capital and the rest of the Province.

It is obvious that most of the confused, depressed, and anxious patients in Manitoba will be treated by the 426 general practitioners, and (although to a lesser extent) by the 309 non-psychiatric specialists. In other words, whether or not doctors who are not psychiatrists wish to see psychiatric patients, their patients will always take their psychiatric problems to them.

In Manitoba, I spoke both to specialists and to general practitioners about their relations with psychiatrists. The ones with whom I talked (like non-psychiatric physicians elsewhere) complained vigorously about their psychiatric services. They found it hard to contact psychiatrists, and had to wait a long time to get appointments for their patients; they were disturbed at their lack of communication with psychiatrists concerning patients; they complained about the reports that psychiatrists send out and said that psychiatrists did not practise like other specialists. For the most part, family doctors were better satisfied with the consultation services provided by psychiatrists in private practice than by those employed in the Government service. The physicians with whom I talked realized that they must treat many patients who had psychiatric complaints; they had no other choice. Many would not refer to psychiatrists because they thought the patients would feel stigmatized. Many family doctors would welcome an opportunity to treat their psychiatric patients in general hospitals, especially if the hospitals had psychiatric consultants available when needed.

These physicians vigorously denied dumping unwanted patients on private psychiatrists or on mental health clinics. They told me that they only referred those patients who did not respond to treatment or who were too difficult for a non-psychiatric physician to handle.

What will be the future role of the family physician in psychiatry in Manitoba? Certainly the increased under-graduate training is improving the psychiatric skill and interest of the younger practising physician; in future, more

general practitioners will willingly accept responsibility for their psychiatric patients. More than any other, the officials of the Government of Manitoba have recognized the role of the family doctor in psychiatry, and indicated that he will be encouraged to treat patients in some of the psychiatric units. Thus family doctors will need to diagnose and treat most psychiatric patients and must be paid for rendering this service. They will need more consultant services from qualified psychiatrists and access to whatever services are developed in the community for the treatment of mental disorder—including help from public health nurses. If the therapeutic role of the general practitioner in psychiatry is to be recognized by the general hospitals, then he will undoutedly require more post-graduate training in psychiatry, and will then be granted hospital privileges according to his demonstrated skills.

5. Public Health Services

The Municipal Public Health Services in Manitoba now play a bigger role in psychiatry. Besides the health services of the City of Winnipeg, there are fourteen public health units in the Province. These fourteen units are under the direction of the Department of Health and Public Welfare, and cover three-quarters of all the population living outside of Winnipeg.

The public health units have 100 public health nurses, and this achieves the generally accepted ratio of one public health nurse to 5,000 population. At the moment, the public health nurses do not play a large role in the rural psychiatric services in Manitoba. If the present trend towards decentralizing psychiatric services continues and results in more psychiatric patients being treated in the community, than the public health nurses will play a larger role. To what extent the present group of public health nurses could add the follow up of psychiatric patients to their current duties is not known.

Once public health units take more responsibility for the community care of the mentally disordered and display greater interest in psychiatric problems, public health officers will need more training and better orientation in psychiatry.

6. Voluntary Agencies

(a) *Canadian Mental Health Association* (3)

The Canadian Mental Health Association has an active Provincial Division in Manitoba. This group took over from an independent volunteer visiting movement called SHARE which was set up in Winnipeg about fifteen years ago. Today the Canadian Mental Health Association has 5,000 members in Manitoba, and has a full-time staff of 5 and the services of 500 volunteer visitors.

Considering its main function to be public education, and pressing for improved legislation and service, the Manitoba Division is trying to bring about changes in the Province's Mental Health Program. The Division seeks legislation to guarantee the civil rights of patients admitted to the hospitals for mental diseases, and asks that most patients be allowed to maintain the right to manage their own finances. The CMHA also requests that patients be paid for the work they do while in mental hospitals. The Association strongly supports the principle of decentralization of psychiatric services, recommending that local

boards operate all psychiatric hospitals and units. The CMHA wants the Provincial Government to get out of the business of running psychiatric services except in so far as it provides operating funds to the local boards.

The Association is pressing for the integration of psychiatry with other medical care, and recommends psychiatric units for many municipalities including Dauphin, Flin Flon and Pine Falls.

(b) *The Association for Retarded Children—Manitoba Division* (4)

Like other provincial divisions of the Association for Retarded Children, the Manitoba organization is healthy and vigorous. Founded in 1953 by a group of six parents, it has since expanded to seventeen branches with a total of 920 members. It operates 47 day classes with 385 students, and has an annual budget of $230,000.

The history of the Manitoba Branch of this Association shows what non-professionals can do when emotionally involved, and it points the way to making greater use of well-informed citizens in all psychiatric programs.

7. Special Items

(a) *Mental Retardation* (2)

There are more than 1,100 mentally retarded patients (all over six years of age) in the Manitoba School for Mentally Defective Persons at Portage la Prairie. There are also facilities for 110 retarded patients of less than six years at the St. Amant ward of the St. Boniface Sanatorium. In addition, there is a boarding school for 18 retarded girls. Trends in the future care of the mentally retarded in Manitoba are influenced by the Association for Retarded Children —referred to in a previous section. These trends (which seem to have Government support) point to the need for (a) more services for diagnosis and consultation, (b) facilities for the pre-school retardates, (c) services for the recreation and the occupation of the adult retarded persons. Above all, there is a need for the rehabilitation of the older retarded person, especially for sheltered workshops that can be used for training, and for the continued employment of those too handicapped to compete in the ordinary work market.

Questions for the future include, who in the Province is to take the lead in planning? Will the leadership come from Government-appointed officials, or from a body that is representative of interested persons from Government and from local units such as the Association for Retarded Children. One pressing question not as vigorously presented to the Government in Manitoba as in some other provinces is the type and location of facilities for the care of the grossly retarded. Will those dependent and sick persons be looked after in a centralized unit as at Portage la Prairie, or in decentralized chronic care beds in local hospitals? Answers to this problem must await further experimental study.

(b) *Child Psychiatry* (2) (5)

Winnipeg has a highly rated child psychiatric service called the Child Guidance Clinic of Greater Winnipeg. It is operated by the Provincial Department of Health in conjunction with No. 1 School District of Winnipeg; it serves a school population of almost 100,000. It now has an annual budget of $375,000, and its staff includes psychiatrists, visiting teachers, social workers and psychologists. The staff of the clinic see more than 3,000 new referrals annually.

Critics of the clinic ask whether its services are not over-extended with the demands being beyond the capacity of the present staff complement.

Other children's out-patient services include a Child Guidance Service attached to the Brandon Mental Health Clinic, and the out-patient services at the Children's Hospital in Winnipeg.

In-patient services are limited to the Children's Hospital which, while it has no specified beds for psychiatric problems, does have a full-time Director of Child Psychiatry.

The future needs in child psychiatry in the Province of Manitoba have been precisely defined by a committee of competent professionals, which has been working on this question for a number of years. The Committee has recommended (a) a 15-bed acute treatment unit for disturbed children at the Children's Hospital, (b) an undetermined number of beds at the Manitoba School for Mentally Defective Persons at Portage la Prairie, which could be used for emotionally disturbed children who are grossly handicapped, (c) a 20-bed unit in the Medical Center in Winnipeg for the treatment of emotionally disturbed children who need in-patient therapy of from one to two years duration, at least. The Committee has also requested facilities for the in-patient treatment of disturbed adolescents.

(c) *Forensic Psychiatry*

The Province has five Provincial jails, and one Federal penitentiary. There is one full-time psychiatrist whose responsibilities are with the reform institutions, and a part-time psychiatrist for the penitentiary. None of these institutions has a fully developed psychiatric service for the diagnosis and treatment of the mental disorders found in those convicted of breaking the law.

The question is whether the reform institutions should develop their own diagnostic and therapeutic services in psychiatry, or call on the Provincial psychiatric services for this assistance. Unless the prisons adopt some of the philosophy and practices of the mental hospital, the mental hospitals may be forced to develop some of the restrictions of the prison; this would be most unfortunate.

(d) *Alcoholism*

The Alcoholism Foundation of Manitoba is an organization established and operated by a board on which the Government has representatives; its function is to find ways of meeting the problem of coping with Manitoba's more than 10,000 alcoholics. At the present time the Foundation operates an administrative office, and a rehabilitation center with ten beds; it also provides out-patient counselling services for alcoholics and for their families.

(e) *Social Work* (2)

There are 19 qualified social workers engaged in psychiatry in Manitoba. These include 10 at the Child Guidance Clinic of Greater Winnipeg, 3 at the Deer Lodge Hospital, 1 at the Selkirk Hospital, 3 at the Winnipeg Psychiatric Institute, and 2 in the Psychiatric Department of the Children's Hospital. There are also 9 partially qualified workers, 6 of whom are in the Child Guidance Center—the others are at units in St. Boniface and the Children's Hospital.

This group of social workers is too small to deal effectively with the social problems of all of the mentally disordered in Manitoba. This points to the serious lack of resources for following up emotionally disturbed patients returning to the community. It is hoped that the Manitoba School of Social Work will provide more qualified social workers, who could act in a consulting capacity to other community workers.

It is clear that the greatest obstacle to improving the community care and treatment of mentally disturbed people is the lack of an interested professional group to aid in rehabilitation. Aside from the need for leadership for such a group, there is a great need for funds to increase the number of professional workers in the community so that more will be available to help in psychiatric rehabilitation.

(f) *Psychologists*

There are 38 psychologists working in the health field in Manitoba—22 of whom are in the Child Guidance Clinic of Greater Winnipeg; others work in some of the general hospitals and in the Provincial psychiatric institutions.

8. Conclusion

(i) Considering its handicaps of size and topography, the Province of Manitoba has an impressive record in the development of psychiatric services.

(ii) Present plans for future integration of psychiatric services with other medical services in Manitoba include (a) 100- to 200-bed psychiatric units attached to general hospitals, (b) encouragement to the general physicians to treat most of their psychiatric patients with the prospect of some general hospitals granting family doctors admission privileges for this purpose, (c) the association of community services outside of Winnipeg with public health units.

(iii) There is active co-operation between the various groups interested in psychiatry in Manitoba. These include the Mental Health Division of the Department of Health, the University of Manitoba, and the voluntary organizations.

(iv) The Government of Manitoba has combined with the Public School Board to produce an active Child Guidance Clinic in Greater Winnipeg.

REFERENCES

(1) Submission by the Government of Manitoba to the Royal Commission on Health Services, January 1962.
(2) *The Manitoba Medical Association,* brief submitted to the Royal Commission on Health Services, December 1961.
(3) *The Canadian Mental Health Association, Manitoba Division "SHARE",* brief submitted to the Royal Commission on Health Services, December 29, 1961.
(4) *The Association for Retarded Children in Manitoba,* brief submitted to the Royal Commission on Health Services, January 1962.
(5) Annual Report of the Child Guidance Clinic of Greater Winnipeg, 1960-61.

CHAPTER 9

TRENDS IN PSYCHIATRIC CARE IN SASKATCHEWAN

1. Introduction (1)

Psychiatry in Saskatchewan has changed a great deal since the end of World War II, and the responsibility for these changes belongs to many people. The Provincial Government opened this era of change in 1949 with the introduction of free care in mental hospitals. In 1947, with the Saskatchewan Hospital Services Plan, care in psychiatric units of general hospitals also became free.

By 1950, more nursing staff and higher salaries increased per diem costs in mental hospitals from $1.45 per patient to nearly $5.00. Along with more staff came more staff training, and in 1947 the mental hospitals expanded their training programs for psychiatric nurses from less than 100 hours to more than 500 hours in three years.

Two other changes have attracted wide-spread attention; the first was the program of psychiatric research which, by 1958, had a budget of $250,000, and secondly a plan for reorganization by which the Government would build several small mental hospitals, each intended to serve a population of about 70,000 people; in 1964, the Government will open the first institution under this scheme—a 150-bed hospital at Yorkton.

Good or bad, psychiatric services in Saskatchewan have always been different. Until 1914, mentally disordered patients from the area were sent to the mental hospital at Brandon. In 1912, the Government of Saskatchewan selected an aggressive and competent physician (Dr. J. J. MacNeill) to plan and build its first mental hospital; this was located on the North Saskatchewan River at North Battleford. To provide service for the southern part of the Province, the Government opened a second institution at Weyburn in 1920.

By 1930, politicians criticized conditions in these two institutions, charging that they were already overcrowded and out of date. As a result, the Government of that day set up a Commission to study the situation and to recommend changes. This study led to the appointment of a Commissioner of Mental Services (Dr. J. J. MacNeill) and to the setting up of a 25-bed psychopathic unit in the Regina General Hospital.

The depression and World War II postponed the construction which the Commission had recommended. This resulted in serious overcrowding in the two institutions and by 1946 there were 4,500 people in buildings meant to house only 2,000.

Concurrently, social changes resulting from depression, war, and the mechanization of farming changed living patterns throughout the Province. More than 300,000 people left farms. Many moved to the cities, and some left the Province altogether. All this increased the number of handicapped and dependent people turned over to Government care. Since Saskatchewan lacked adequate homes for the aged, and hostels for the homeless, many people cut adrift by the population change were admitted to mental hospital; often they remained in these institutions even though their mental handicaps were not great.

By 1946, it was evident that radical changes were needed in psychiatric care, and that conditions in the mental institutions (especially in Weyburn) were indefensible. All authorities agreed on the need for changes, but there was much disagreement on the form these changes should take; although by 1961 there was still some disagreement on the future pattern of care, many interesting changes had been made.

2. Mental Hospitals (2) (3) (4)

By 1960, Saskatchewan had more than 12,000 hospital beds of which 4,500 were for patients with psychiatric disorders. The northern part of the Province had one institution with 1,590 beds at North Battleford for the treatment of mental illness, and for Southern Saskatchewan there was a hospital at Weyburn with 1,575 beds; thus for a population of 900,000 people, Saskatchewan had 3,300 beds for psychotics. By 1960, the Government was also planning the construction of a 150-bed regional mental hospital at Yorkton—the first step in the Saskatchewan Plan.

To look after the 3,200 psychotics and the 1,500 mental defectives in provincial institutions, and to run its mental health clinics, the Province employs 54 physicians—15 of whom were certified as specialists. It is difficult to recruit psychiatrists to the provincial service—especially Canadian psychiatrists. For many years, most of the recruits have come from European and Asiatic medical schools—many moving North after being forced to leave the United States because their student immigration visas had expired. Thanks to these foreign medical graduates, the hospitals have had enough doctors, but improvements in conditions of practice in other countries, especially in Great Britain, could quickly cut off this supply.

To improve medical recruitment, and to keep the doctors it now has, the Saskatchewan Government has introduced a pay scale which, in 1963, was higher than that of any other province. A senior psychiatrist could receive an annual wage of up to $16,000, a clinical director $20,000, and a medical superintendent $22,000; years ago nobody dreamed of such incomes for psychiatrists in provincial mental hospitals.

The per diem cost for psychiatric patients in Saskatchewan was $5.50 in 1962. It is not easy to compare this with general hospital costs because the latter cover fewer items. For example, psychiatric budgets include salaries to doctors and clothing for patients; in some instances they also include the costs of mental health clinics. It is also difficult to determine the effect of Federal Government grants on per diem rates. A rough comparison shows up in the information that the less than 7,000 beds under the Hospitalization Plan cost $38,000,000 annually, whereas the gross cost of psychiatric care (including clinics) for about 4,500 mental patients is $10,000,000. From this it appears that the per diem cost in general hospitals is more than three times that in mental hospitals.

To operate its psychiatric institutions (including those for the mentally retarded) Saskatchewan has ward staff of 1,238. Only 24 of these professional people are registered nurses; more than 600 are registered psychiatric nurses who have taken the 613-hour three-year training program provided in each of the three provincial institutions.

The mental hospitals in Saskatchewan first set up a training program for nurses in 1930 and expanded this in 1947; now the three training schools each year graduate a total of about 90 psychiatric nurses. These nurses have their own professional organization which was established in 1948, and is known as the Saskatchewan Psychiatric Nurses Association; together with similar groups in Manitoba, Alberta and British Columbia, the Saskatchewan psychiatric nurses form part of a National Council.

The graduates of this ward training program have provided Saskatchewan institutions with good nursing care. Some of these nurses are employed in the psychiatric units in the Province's general hospitals, where they have helped to demonstrate the importance of the nurse in psychiatric treatment. A few of these registered psychiatric nurses have worked in the social service programs of mental hospitals.

Since they have no official status with the Registered Nurses Association, what is the outlook for this mental hospital trained group? This depends on where the mental patient will be treated in future. If he still goes to the large or even to the small mental hospital, then the registered psychiatric nurses will, of course, continue to provide most of the nursing care. If, on the other hand, there is a closer integration with general medical care, with most psychiatric treatment given in the community or in the community's general hospital, what will become of the mental hospital trained psychiatric nurses? Already they have shown how they can hold their own working with psychiatric patients in general hospitals; if mental hospitals should disappear, I believe the mental hospital trained nurses will be needed not only in the general hospitals, but also in the community services and in psychiatric follow-up programs.

In its psychiatric services program, in addition to doctors and nurses, the Province employs 21 social workers and 14 psychologists. Both of these professional groups have been deeply involved in the change in emphasis from the mental hospital to the community.

Although neither of the two large hospitals is completely open, the number of open wards increases each year, as more freedom is given to the patients. Nine hundred of the 1,500 patients admitted each year to the two mental hospitals are first admissions. The average age of admissions is increasing and so is the average age of the total in-patient population. The rate of discharge is less among older patients than in the younger groups so that most patients with a diagnosis of depression or schizophrenia are discharged and a higher percentage of the seniles and arteriosclerotics are not. Thus the institutions are gradually becoming giant homes for the aged.

There is much interest in Saskatchewan, and elsewhere, in what is known as the Saskatchewan Plan. This is the proposal to build small regional psychiatric hospitals which the Psychiatric Services Branch is espousing. Those who push the Plan believe that the present large mental hospitals cannot provide an adequate service for the people of Saskatchewan; at the same time, they believe that the integration of psychiatric care into general hospitals by opening small psychiatric units within them is not a suitable alternative for the large mental hospitals.

The Saskatchewan Plan provides for the building of eight regional mental hospitals, each of 150 to 250 beds, each serving a population of from 60,000 to 90,000 people. The two large mental hospitals, at present in operation, would then be reduced in size and each serve a population of 150,000 to 200,000 people. The regional hospitals would be built as close as possible to local general hospitals, although administered separately. The standard of care provided in the mental hospital would equal that of the general hospital.

Most critics believe that the decentralization of psychiatric services from a large to a small regional hospital would be an improvement; it is another matter again to determine whether the small mental hospital in an integrated regional set-up would be superior to a psychiatric service in a general hospital—especially one that was closely integrated with the non-psychiatric medical services in the hospital and in the community. Only time and appropriate pilot projects will ascertain which type of service is best suited for the Province of Saskatchewan.

3. Mental Retardation (5)

At the present time Saskatchewan has two provincial institutions for the care of the mentally retarded. In 1954, the Provincial Government opened a new institution at Moose Jaw for the care of mental defectives; today, this so-called training school has 1,128 patients. In 1961, the Government converted a former tuberculosis sanatorium at Prince Albert into a 350-bed unit where it now houses lower grade mental defectives; even so, 160 severely retarded patients still remain in the Saskatchewan Hospital in Weyburn. In addition to the 1,600 mentally retarded in institutions, there is a list of nearly 500 mental defectives who are waiting for admission. The present rate of admission is about 60 per year.

There are 60 special classes with a total of 900 pupils for the mentally retarded in 19 public and separate schools in the Province. In addition, 280 mentally retarded children attend special classes set up under the sponsorship of the Saskatchewan Association for Retarded Children; the Provincial Government aids these classes with financial grants. Other sources of help for the mentally retarded include (1) consultation services from the Provincial Mental Health Clinics, (2) support from public health nurses in the health regions, (3) some assistance in the rehabilitation of higher grade defectives by the Council of Crippled Children and Adults.

An understanding of the extent of the problem is helpful to those trying to plan better services. If one accepts the estimate of 2 per cent of the population as retarded (some prefer an estimate of 3 per cent) this would mean about 16,000 mentally retarded in Saskatchewan; thus the 1,600 in institutions make up 10 per cent of the total. By E. O. Lewis' 1929 estimate (which divides the mentally retarded into 75 per cent educable, 20 per cent trainable and 5 per cent wholly dependent) there would be 12,000 educable, 3,000 trainable, and less than 1,000 entirely dependent persons in the Province of Saskatchewan. If one compares this with the number in each group now in institutions, it would appear that the institutions now contain half the total of the Province's severely retarded, about 25 per cent of the trainable group, and less than 3 per cent of the higher grade.

The Canadian Association for Retarded Children has taken the lead in pointing out the deficiencies in the present care of the mentally retarded, and its leaders have made some wise suggestions for improvement. They have asked the Government to provide counselling services for those parents who keep their

retarded children at home, and they have asked for funds to help these parents look after their children; they have asked for more teachers to be trained to work with the mentally retarded, and they have requested the Government to set up sheltered workshops to assist in the rehabilitation of both the middle- and high-grade groups.

The recommendations of the Association for Retarded Children point up certain questions. Should those who counsel the parents of the retarded restrict their activities to this work alone or should this counselling be part of the duty of public health nurses and other workers already in the community? Although having counsellors specializing in mental retardation might be more efficient, it would emphasize the separateness of this group from the community. Should sheltered workshops prepare some of the higher grade group for regular employment and, at the same time, give permanent employment at appropriate pay to severely handicapped people who could never compete for jobs in the open market? Most of those interested say "yes" to this.

Some want the care of the mentally retarded more closely integrated with existing health and educational programs. In this situation family physicians would be trained to diagnose mental retardation, and to counsel the parents of retarded children—at all times, of course, having available consultant advice from specialists in the field. Local schools would then provide facilities for the middle- and high-grade defectives. Some of the totally dependent would be kept at home, with health authorities giving professional and financial assistance to the parents. Others in this dependent group would be admitted to chronic care units near local general hospitals. The community would have to provide sheltered workshops for those who could not be employed elsewhere and help train others who had the potential to enter industrial employment; some members of both groups will require hostel accommodation, best located near the sheltered workshop. Such local arrangements would replace the present practice of admitting and keeping patients in the large provincial institutions.

4. Community Care (2)

The Province has six full-time mental health clinics operated by staff employed by the Psychiatric Services Branch; these clinics are at Regina, Saskatoon, Swift Current, Prince Albert, Yorkton and Moose Jaw; the staff of the University Hospital also operates an out-patient service in Saskatoon. These seven groups see a total of more than 5,000 out-patients annually. There are also 15 part-time clinics which travel from central offices located at Weyburn, North Battleford, Regina, Prince Albert, Swift Current and Yorkton; these pay regular visits to many Saskatchewan communities at intervals varying from weekly to monthly. The staff of the travelling clinics sees about 1,000 referrals each year. They provide consultation services to Saskatchewan's 750 practitioners and to community agencies, and the full-time clinics carry on some out-patient treatment.

Should the clinics concentrate on providing consultation services to physicians and agencies or should the clinic staff do more out-patient treatment? Since in all the clinics at the present time the staff see not more than 40 patients a day, and since each day the 750 non-psychiatric physicians in the Province see more than 4,000 patients with complaints which are primarily psychiatric, the importance of the consultation role becomes clearer. The members of the clinic staff are more useful as consultants than as therapists.

5. Public Health

In 1946, the Government of Saskatchewan transferred the responsibility for the mentally ill from its Department of Public Works to the Department of Public Health; since that date, the Minister of Public Health has been responsible for the Province's psychiatric services. He gives the Director of Psychiatric Services a rather free hand in planning his program and operating the Branch; as elsewhere, neither psychiatrists nor the public health administrators know quite what to make of this uneasy alliance between psychiatry and public health administration.

Saskatchewan has a well-organized program of community public health. The Province is divided into twelve regions—each under a medical officer of health who reports both to a local regional board and to his branch head in Regina. The medical health officers vary a good deal in their interest in psychiatry, and in their psychiatric training; they would need extensive refresher courses if they had more responsibility for psychiatric patients.

Through their contacts with homes and schools, the 120 public health nurses in the twelve regions encounter many psychiatric problems. Between 1946 and 1954 the newly hired public health nurses were seconded in rotation for orientation periods of one month's duration to one or other of the two mental hospitals; this stopped because of shortage of recruits and a great staff turnover. Because of this experience or because of other training, some public health nurses have considerable interest and competence in psychiatry—some are now actively engaged in assisting parents who have mentally retarded children.

In the future, the psychiatric patient is more likely to receive treatment in the community than in hospital. With the patient convalescing at home, both he and his family will need more help and advice. Here seems to be a function that the public health nurse could well fill. Working closely with the patient and his family, she could give invaluable assistance both to the family physician and to the consulting psychiatrist. If this responsibility is to be given to public health nurses, the number of public health nurses will have to be increased by at least 10 per cent—probably by 20 per cent.

6. General Medical Services

(a) *General Hospitals* (6)

Whether in future psychiatric care is given in big mental hospitals, little mental hospitals, or in general hospitals, the general hospital is bound to play an important role. In Saskatchewan there are more than 6,000 beds in 157 general hospitals which vary in size from less than a dozen beds to one institution with nearly 800. Nineteen of these hospitals have more than 70 beds; 14 are located in urban centers of more than 10,000 people.

Although no accurate count has been made of the number of psychiatric patients occupying general hospital beds, it is estimated that from 15 to 20 per cent of the beds in public general hospitals are filled by patients whose chief symptoms result from mental disorder. These include the confused, depressed and anxious people who find their way into medical, gynaecological, and even surgical wards.

If, as is suggested here, a large number of the patients (even as many as 15 to 20 per cent) in medical and surgical wards actually suffer primarily from

psychiatric disorder, this information does not appear in the hospital statistics. In 1960 only 3,959 of 190,000 patients discharged from Saskatchewan general hospitals were listed under psychiatric diagnoses—most of these would be from the psychiatric units. Hence, if there are psychiatric patients in medical and surgical wards, these must be under non-psychiatric diagnoses; it would seem wise to make a precise study of this. It is useful to note here that the average stay for all patients in Saskatchewan general hospitals is 10 days—compared to 20 days for patients in psychiatric units.

Yet only 95 of Saskatchewan's more than 6,000 general hospital beds are in psychiatric wards. These wards at present include the Munroe Wing, which was opened in the Regina General Hospital in 1930 and now has 35 beds, the Psychiatric Unit which was opened in the Moose Jaw General Hospital in 1954 with 20 beds, and the Psychiatric Department of the University Hospital, Saskatoon, opened in 1955 with 39 beds; the first two are staffed by the Psychiatric Services Branch and the third by the university.

All three are open wards which accept all types of patients. They have demonstrated that it is possible to treat any type of psychiatric patient in an open ward in a general hospital. When someone questioned whether the psychiatric ward in Saskatoon was really getting a cross section of the most disturbed patients, the staff at the University Hospital set up a research project to find the answer. During a two-year period, six beds in the psychiatric unit were set aside for patients selected from a random sample of persons certified for admission to the Saskatchewan Hospital at North Battleford; these certified patients caused no more administrative problems in the University Hospital than had the average patient in the unit. This demonstrated that the ward could treat the most difficult patients.

Even though it is possible to admit and treat all types of patients in an open general hospital unit, admittedly, this, in itself, does not mean that this is necessarily as good or better than treating the same patients in a mental hospital; we just don't know. Even though senile patients can be treated in a psychiatric ward (and most sent home) it appears that without good follow-up in the community, large numbers of these eventually end up in mental hospital.

Whether in future, Saskatchewan will look after its mentally sick in big mental hospitals, small mental hospitals, or in wards of general hospitals will depend on which of the three methods prove best; experience and research during the next 10 years will tell us much. If, as I believe, it will prove possible and wise to make psychiatric care part of general medical care, how many extra beds would be needed in general hospitals? So far the Manchester Hospital Region has provided the best answers to this. In the psychiatric units of general hospitals in Bolton and Blackburn, and in other cities of the Manchester Region, consultant psychiatrists believe they can provide all the psychiatric hospital service needed with .5 beds per 1,000 population: many of the cities in the Manchester Hospital Region have about 100 acute beds for 200,000 population. The chronic schizophrenics are treated on an out-patient or day-patient basis—patients with psychoses of the aged are not admitted to the psychiatric service, but enter the quite good geriatric services located in the Council hospitals. In Oldham, however, which is also a Manchester Hospital Region center, patients with psychoses of the aged are admitted to the psychiatric service rather than to the geriatric service. To look after both the confused old people and the acute patients, the consultant psychiatrist here thinks he needs a total of one bed per 1,000 or .5 more beds than provided for the acute cases alone in Bolton and Blackburn.

Translating this into the Saskatchewan situation, making due allowance for the 3.5 beds per 1,000 population for acute and chronic psychotics which the Province now has, I believe that for the general hospital to replace the mental hospital would require at least .8 beds per 1,000 for acute cases, and .5 per 1,000 for long-stay senile dements; this would make a total of 1.3 beds per 1,000 or about 1,400 psychiatric beds for the Province of Saskatchewan. (This would not include beds for the mentally retarded.) With the two large mental hospitals still very much going concerns, and with at least one small mental hospital now being built at Yorkton, even if general hospital care now was considered better, it would be many years before all the psychotics in this Province could be treated in general hospitals.

Assuming that the time did come when all psychiatric patients were cared for in general hospitals, how, in Saskatchewan, with its present population and present set-up of general hospitals, might the psychiatric beds be distributed? In eight Saskatchewan cities with populations of more than 10,000 people, there are now 13 general hospitals; in addition, there are general hospitals in the relatively important population areas at Melfort, Estevan and Melville. It would seem appropriate to have units for psychotic patients in each of Saskatoon's three hospitals, and in each of the two hospitals located in Regina, Moose Jaw and Prince Albert, as well as units in the general hospitals in Weyburn, Swift Current, North Battleford, Yorkton, Melfort, Estevan and Melville. If 800 acute psychiatric beds were distributed between these 16 units, each would have an average of about 60 beds, varying from 20 to 90 beds, depending on the size of the hospital. Since most of the long-stay patients are in the older age group, each of these hospitals would also need an average of 25 to 30 long-stay beds, which would best be located in chronic care wings of the hospital.

A proposal to treat all hospitalized psychiatric patients in general hospitals raises many questions—particularly in regard to staff. Each of the 16 units proposed above would require one or more consultant psychiatrists, but in each unit most of the patient care would be by residents in training or by family physicians.

One final question is whether all confused, depressed and anxious patients requiring hospitalization need to be in separate wards, or could be cared for in the regular medical wards. Once the nurses in the medical wards have had adequate psychiatric training, it may prove feasible to care for most psychotics in wards with other medical patients—with advantages to both groups.

One cannot conclude a discussion of the program outlined above without reiterating the need for much research before such comprehensive care in general hospitals could be achieved. We need to learn much more about the difficulties of treating all psychotics in general hospitals, about the advantages and disadvantages of the patients to being treated in general hospitals, and about the need for the better community facilities that would certainly be required if the number of hospitalized psychotics was to be reduced from the present 3.5 per 1,000 to 1.3 per 1,000.

(b) *Practising Physicians*

Of Saskatchewan's registered physicians, 755 practise privately—about two-thirds of these are general practitioners. Saskatchewan also has 76 doctors working in country districts under contract arrangements with their rural municipality; thus 76 of the Province's 322 rural municipalities employ a physician under the Municipal Doctor Plan.

A representative group of the Provincial College of General Practice, meeting in December 1959, estimated that 25 per cent of the patients in office practice came only because of psychiatric complaints or at least have serious psychiatric disorders in addition to a physical illness. A quick calculation of the number of physicians in general or specialist practice in the Province, and of the average number of patients seen by them each day, indicates that each working day the non-psychiatric physicians in Saskatchewan see a total of more than 4,000 patients with serious psychiatric handicaps. Saskatchewan has about 30 certified psychiatrists; these are the specialists available to see patients referred from general physicians, but the time these specialists have for such consultations is limited by their responsibilities for teaching, research, and administration of psychiatric wards. So it is doubtful whether the Province's qualified psychiatrists see more than a total of 40 out-patients a day (compared to the more than 4,000 seen each day by other doctors).

Since it would be impossible for non-psychiatric physicians to stop practising psychiatry, the question is how to help them do it better. Certainly medical colleges must provide intensive under-graduate training in psychiatry with more supervised experience in diagnosis and treatment. An increase in the number of psychiatric services attached to general hospitals could improve the psychiatric training of interns; the presence of more psychiatrists in general hospitals will make psychiatric consultation service on the non-medical wards easier and better.

For the past several years the Department of Psychiatry at the University Hospital in Saskatoon has had a general practitioner on staff. He has had two psychiatric beds to which he admitted those patients from his practice who required psychiatric treatment in hospital. This experiment has demonstrated that general physicians can treat the psychiatric disorders of their own patients on psychiatric wards, and that the contact between psychiatrists and family doctors which results from this helps both the physicians and the patients. Thus it would seem advisable in all large general hospitals to set up experimental wards to which general practitioners could admit patients with psychiatric disorders, and where, with help from a psychiatrist attached to the service, they could treat these mental patients. Most family doctors now do treat patients with psychiatric disorders on medical wards, and regardless of whatever other psychiatric service is provided, will continue to do so. Having better communication with psychiatrists would make their treatment more effective, and the family doctor would learn more psychiatry. He would then use the psychiatrist as a consultant, in the same way as he now uses the internist and the surgeon.

Occasionally psychiatrists now go to rural hospitals to see patients in consultation with a family physician; this should be greatly increased. Each hospital should have visits at regular intervals from consultant psychiatrists who would advise the practising physicians concerning individual patients and establish policies for the care of those mental disorders that family doctors treat in local hospitals. Where could the Province obtain the psychiatrists required for such a program? Surely, Saskatchewan cannot increase its present number of qualified psychiatric consultants fast enough to add this heavier load to present duties. To extend consultation services in this way could only be done by rearranging the duties which psychiatric specialists now perform. The psychiatrist would have to spend less time carrying out what is really general practice psychiatry, and thus have more time available for backing up general physicians.

7. Voluntary Agencies

(a) *The Saskatchewan Association for Retarded Children* (5)

The Saskatchewan Association for Retarded Children was founded in 1956 by a group of parents of retarded children. Thanks to a small band of devoted workers, the organization has flourished and accomplished much. It has raised funds, opened schools, and brought the problem of mental retardation to the attention of a great many people in the Province.

The Association is the Provincial Division of a National Association. The Province has 20 local branches—each with an average membership of 50 persons. Forty other communities, without branches, have local representatives.

The Association has an annual budget of $50,000 which, except for an $8,000 grant from the Provincial Government, it raises through an annual fund drive. Wherever possible, instead of starting new services, the executive members of the Association try to increase the work which the existing Health and Welfare services now do for the mentally retarded; in other words, they encourage schools, employers and others in the community to integrate the mentally retarded into their regular programs. Members of the Association operate pre-school classes at Saskatoon, North Battleford and Prince Albert. They supply equipment and transport to those schools at Regina, Moose Jaw and Saskatoon, that now have classes for the retarded. The Association contributes funds for research on mental retardation. Each year it presents the Government with a brief which reports the current needs of the mentally retarded.

In Saskatoon I talked with Mr. John Dolan who took the lead in organizing and operating the Division in Saskatchewan (in recognition of his efforts, the center at Saskatoon was named the John Dolan School). Mr. Dolan says that the Saskatchewan Association for Retarded Children is particularly anxious to use existing services rather than to create new ones; that the present trend is towards having the family physician of the future trained and motivated to diagnose and treat the mentally retarded in his area; that public health nurses need proper training so that they can counsel the parents of the retarded. As far as possible, according to Mr. Dolan, the local school boards should set up school facilities for all three divisions of the mentally retarded. The municipalities should provide local accommodation in chronic hospital units for the severely retarded (especially those with physical disability). With provincial help, the municipalities should also establish sheltered workshops for those past school age who either need experience before entering the labour market, or who may have to work permanently in a sheltered workshop. For those who live at a distance or have no home, there should be hostels attached to these workshops.

(b) *The Canadian Mental Health Association* (7)

The Saskatchewan Division of the Canadian Mental Health Association was founded in 1949. It now has 32 branches and committees, and has local contacts in 400 other communities. Counting those who contribute to its drive as members, it now has a membership of 50,000 and a budget of more than $100,000 annually. The Association carries on public education—with about 500 educational meetings a year, and many workshops and seminars. It contributes more than $10,000 annually in support of psychiatric research and operates White Cross Centers in Regina, Saskatoon, North Battleford, Weyburn and Yorkton; each month the total number of ex-patients attending these centers exceeds 800. It operates a regular program of volunteer visiting to mental hospitals at Weyburn, North Battleford and to the Munroe Wing in Regina.

Plans for the future envisage more support of research, and the opening of more White Cross Centers.

(c) *The Saskatchewan Council for Crippled Children and Adults*

This organization accepts the mentally retarded and, to a lesser extent, the mentally ill, as suitable referrals to its program. It operates summer camps. In its rehabilitation program it has a testing service, and a sheltered workshop of limited capacity. As far as the mentally disordered are concerned, its rehabilitation services are quite inadequate to meet the needs, but it does point the way for the future. In future, the rehabilitation of the mentally disordered in Saskatchewan is likely to be more closely integrated with the rehabilitation of other handicapped people; the segregation of the mentally ill should cease.

8. Special Psychiatric Services

(a) *Child Psychiatry*

All of the Province's full-time mental health clinics accept referrals of children with psychiatric disorders, but only the MacNeill Clinic in Saskatoon provides extensive service for children. Recently the University Hospital added a child psychiatrist to teach medical students more about the diagnosis and treatment, in general practice, of the emotional disorders in children. In conjunction with the Faculty of Education in the university, the school boards of Saskatoon plan to set up a comprehensive service for the diagnosis and treatment of psychiatric disorders of children. Those who teach teachers at the university would make use of this service in preparing teachers to handle the emotional disturbances in the classroom.

Saskatchewan's general hospitals have no in-patient services for mentally disturbed children, although, more or less by accident, some psychotic and neurotic children do get into the Training Schools for the Mentally Retarded at Moose Jaw and at Prince Albert. The University Hospital has plans for a ward for paediatric psychiatry in the proposed extension to its paediatric facilities.

(b) *Mental Disorders of the Aged* (8)

Of Saskatchewan's residents, nearly 10 per cent (more than 85,000) are over age 65 years of age. At any one time, more than 5 per cent of these old people live in institutions operated by the Government or by voluntary organizations. This group of old people includes more than 1,000 in hostels, 800 in general hospitals (of whom 375 have been classed as long-stay), 575 in provincial geriatric centers, 500 in privately operated nursing homes, and about 1,200 in mental hospitals; in addition there are more than 1,000 old people in low rental houses clustered about hostels for the aged.

In his Newcastle Survey, Roth has estimated that 30 per cent of all persons over 65 have significant mental disorders, and that at least 8 per cent of the total group are moderately psychotic. This would mean more than 7,000 psychotic old people in the Province, with another 20,000 being, to a lesser degree, emotionally handicapped. The only mentally disordered old people now under the care of psychiatrists are the 1,200 in mental hospitals; these include about 600 with recently acquired brain damage plus 600 long-stay schizophrenics who have grown old in hospital.

It is clear that many of the 575 persons in the four provincial geriatric centers (Regina, Saskatoon, Melfort and Wolsely) suffer from psychiatric

disabilities—as do a large percentage of those in nursing homes, hostels and even in general hospitals. How best can the Province provide psychiatric care for the old people who need it? Most aged people with organic confusion or emotional disorder come first to the attention of their family physician; thus he needs some interest and skill in dealing with psychiatric disorders of the old. Many disturbances of the old are transient, and so, if well handled, the patients can remain in the community. To help him understand and plan for these patients, the family doctor must have ready access to consulting psychiatrists. Since most confused old persons also have physical disorders, many brain-damaged old people should be first admitted to general hospitals, where they can be examined physically and where a program of physical and psychiatric treatment can be set up.

Most old people who suffer from mild mental disorders can return home, especially if their families receive help through home care programs; in co-operation with family physicians, several large general hospitals have set up home care facilities. To look after large numbers of mentally sick and physically sick old people in the community, the family doctor will need help not only from the hospital and from the psychiatrist, but also from social workers and public health nurses.

At present, many of the 3,200 beds in Saskatchewan's institutions for psychotics are occupied by patients who do not need hospital care. Probably from one-third to one-half of the old patients in mental hospitals could be cared for at home, in boarding homes, or, if these were available, in hostels. Saskatchewan has a program that provides low-cost housing for old people in the vicinity of hostels. This is financed through arrangements with the Central Mortgage and Housing Corporation and was authorized by the National Housing Act of 1954. For self-contained units adjoining a hostel, the Government provides a grant of 20 per cent for building costs plus a maintenance grant. The sponsoring group (whether religious or municipal) provides 8 per cent of the cost and the remaining 72 per cent is raised through a Central Mortgage and Housing Corporation loan. The increasing age of the population, and the increasing tendency for people to move about will make more of such arrangements necessary. The family physicians who look after the health of the patients in these housing schemes must help those with mental disorder, and need consultant psychiatrists to back them up.

As patients in hostels get older, they accumulate more mental and physical disabilities, and as they become more infirm, some, if not all, of these hostels will have to add additional staff—just to look after the bodily needs of frail old people.

Once an old person in a hostel (or for that matter in a boarding home or even in the home of a relative) becomes so sick (either mentally or physically) as to require both skilled nursing care and the constant attendance of a physician, that person should be looked after in a ward that is part of a general hospital. Some of these patients may require hospitalization for periods of many months or even years. These are sick people who need modern hospital facilities, and require doctors and nurses who are competent to treat people who are mentally ill and physically ill. Most mental hospitals lack both the physical facilities and the skilled medical and surgical staff needed for treating such sick people. Wings built onto general hospitals would seem to provide the best arrangement for treating these sick old people; the nearer the patients are to home, the better—provided medical and nursing care is good.

How many beds would be needed so that the general hospitals would not choke up with long-stay patients? The experience in Manchester suggests that in an active continued care unit with rehabilitation, and with a policy of moving out those able to go, such service can function with less than .5 beds per 1,000 population. The patients in these beds could be treated by their own family doctor in consultation with internists and psychiatrists attached to the acute services in the hospital.

For Saskatchewan to set up such a service it would seem wise to start with one or two pilot projects, adding additional long-stay wings to other general hospitals only after the pilot projects have been evaluated and proven satisfactory. Those evaluating the projects should consider cost, the role of the family physician in caring for this group, and how to retain these facilities for those who really need them.

(c) *Rehabilitation*

In the past, the staff members themselves of the mental hospitals have always had to do whatever was done to rehabilitate the mentally disordered. The separation of the mental hospital from the community made their task more difficult, and patients tended to accumulate in the institution. The community presented few work opportunities for the brain-damaged, for the schizophrenic and for the mentally retarded. Persons with such real or fancied handicaps could not meet the standards demanded by the present minimum-wage laws; hence, many mentally disordered persons discharged from hospital vegetated in unproductive idleness. Mental hospitals have accumulated great numbers of unemployed persons working in unpaid tasks about the institution.

To change this, several British mental hospitals organized sheltered workshops within the institutions, paying the patients what they earned; this has led to the return of many of these patients to paying jobs in the community.

Most people recovering from schizophrenic or depressive illnesses, or adjusting to brain damage, cannot compete unaided in the labour market; nor can the mentally retarded. They do best when started out in a sheltered workshop where they can work to the limit of their capacity, and where they can be paid according to what they do. Small sheltered programs now exist in Saskatoon, Regina and Moose Jaw, but only a limited number of psychiatric patients can use these. Unless these programs can expand to help rehabilitate most convalescent mentally disordered patients, then separate sheltered workshops should be set up just for the rehabilitation of the mentally disordered. I believe, however, that psychiatric patients could be rehabilitated more easily and more effectively along with other handicapped people—and not kept separate. The Province needs pilot projects in rehabilitation, including sheltered workshops. More of the rehabilitation dollar which the Federal Government now grants to the provinces should be spent on the re-ablement of the mentally disordered.

(d) *Alcoholism*

According to the Jellinek Formula, Saskatchewan has about 10,000 people who are severely handicapped by the way they use alcohol. About eight years ago, the Provincial Government established a Bureau on Alcoholism to study this problem and to deal with it. During the intervening eight years, this Bureau has made but limited progress. It has set up a good educational program, and has interested many people in the problems of alcoholism. It has supported those in

the Province interested in alcoholism, including Dr. A. Hoffer, Director of Research in the Psychiatric Services Branch of the Department of Public Health. The Bureau has set up one counselling and referral center in the City of Regina.

Most general physicians still complain that they cannot get help for their alcoholic patients. General hospitals usually won't admit alcoholics for drying out. Mental hospitals retain the alcoholic only a few days, and then discharge him to what the practising physician considers is an inevitable return to drink. Most psychiatrists find the treatment of acute alcoholism difficult, and at present an unsatisfactory task.

Nonetheless, the problem is acute, and somebody must do something about it. Psychiatrists with a research bent should establish pilot projects for the treatment of patients under the acute effects of alcohol, and for the follow-up of chronic alcoholics. Saskatchewan would do well to profit by the experience of the Alcoholism Foundation in Ontario, and then set up an organization which would co-ordinate the efforts and the interest of the family physician, of the psychiatrist, of A.A., and of the volunteer groups. Research is needed on methods of organization and treatment, but the problem is so serious that Government action is urgently needed now.

(e) *Forensic Psychiatry*

At any one time, the two mental hospitals in Saskatchewan, on the average, contain a total of about 60 patients who are detained by Lieutenant-Governor's warrants. Of this group, about 35 per cent had been admitted after juries had declared them unfit to stand trial; these patients could return later to court to be tried. Another 30 per cent have been tried, and found "Not Guilty Because of Insanity", and are now being kept in hospital until the Lieutenant-Governor says they can be released. Of the group kept in mental hospital under Lieutenant-Governor's warrant, about 25 per cent have been transferred from Provincial jails because while serving sentence they became mentally sick; another 10 per cent came for the same reason from the Penitentiary at Prince Albert.

The practice of using Provincial Mental Hospitals to detain acutely disordered persons charged with crime or serving sentences began at a time when most people thought of the mental hospital as a custodial institution. Now that psychiatrists try to provide therapy and rehabilitation (rather than custody) their efforts to improve psychiatric care are impeded by patients in hospital on a Lieutenant-Governor's warrant. For the doctor in charge of the ward cannot ignore entirely the security requirements involving those charged with crime, nor can he lock up this group without unnecessarily restricting the activities of other patients on the same ward who are not security risks.

It seems wrong to allow the needs of 60 individuals to handicap the treatment of 3,000. To cope with this small group, I think that those in charge of the Federal Department of Justice should co-operate with the Provincial Attorney General in establishing psychiatric services within the framework of both Departments. This would mean developing psychiatric services in jails and penitentiaries. It would also mean, in these correctional institutions, setting up hospital beds for the mentally sick. If he is legally not guilty of crime because of mental illness the patient could not be kept in the jail or penitentiary, surely the Department of Justice or the Attorney General could then establish alternative facilities in a special institution not connected with the Province's services for the mentally ill. With such a program, the Province could get on with the job of improving its own psychiatric services unhampered by the security

precautions associated with crime, but at the same time having the jails and penitentiaries set up their own psychiatric services which should have a good effect on the way their administrators regarded aberrations in human behaviour.

(f) *Legislation*

In a recent revision of its legislation for dealing with the mentally disordered, Saskatchewan has moved well ahead of the other nine provinces. As in the 1959 legislation in Britain, the recently passed Mental Health Act in Saskatchewan has made admission of psychiatric patients very much like the admission of any other patient to any hospital.

Unless actively resisting, almost any psychiatric patient can, on an informal basis, be admitted to a hospital bed either in a psychiatric unit or in a mental hospital, or in a training school for the mentally retarded; for this no physician's certificate is necessary. True, a few patients do require certification; the Act provides that these should be reviewed frequently, and when possible transferred to informal status. Those who, after repeated re-evaluations, have remained as involuntary patients have access to an Appeal Board which, among its three members, includes a physician and a lawyer. If the Appeal Board decides that the patient should be discharged, he is.

The Act has simplified the classification of mental disorder, and has made the same provisions for the admission of mentally ill, the mentally retarded, the addicts, the epileptics, the psychopaths, and the psychoneurotics.

In the past, certification meant the loss of an individual's right to manage his own property; under Saskatchewan's new Act, the capacity to administer property is separated from certification.

(g) *Psychiatry in Private Practice*

The Province has three psychiatrists in private practice, all of whom are located in Regina and Saskatoon; each maintains his own office, and has admission privileges in the psychiatric ward of the local general hospital. Each is paid directly or indirectly from funds administered by the Medical Care Insurance Commission.

Since all residents in the Province are now covered by Medical Care Insurance, psychiatrists in future are more apt to be paid in the same manner as other physicians. This will likely mean fewer on salary—more by fee-for-service. Without arguing the relative merits of salary and fee-for-service, there seems little justification for using methods of financing psychiatric care that differ radically from the methods of financing other medical care.

(h) *Medical Education*

The Department of Psychiatry of the University of Saskatchewan participates in under-graduate education for medical students, and in co-operation with the units of the Provincial Psychiatric Services Branch, it operates a post-graduate training program.

At Saskatoon, psychiatry is taught in all four years of the medical course. The aim of the university Department is to prepare the student to diagnose and treat most of the psychiatric problems that he will encounter in general practice; he is taught to use the psychiatric specialist as a consultant rather than as one who would take over the treatment of all psychiatric patients. Generally

speaking, the members of the Department consider psychiatric illness as part of the general medical problem and try to prepare both under-graduates and those taking post-graduate training in psychiatry to treat the mentally disordered in the community's regular health facilities, which means in the office of general practitioners, and in general hospitals, with help from the staff of public health units.

(i) *Research*

On a per capita basis, the Province of Saskatchewan has the largest psychiatric research program of any province in Canada; more than $250,000 is spent each year in psychiatric research.

Within the Psychiatric Services Branch of the Provincial Department of Public Health, Dr. Abram Hoffer operates a program that accounts for most of the Province's organized research. This program began in 1952 with research on schizophrenia; his group is now also interested in alcoholism, senility, and mental retardation. Although a unit of the Department of Public Health, the program is centered in the University Hospital at Saskatoon; it also has projects at Saskatchewan Hospitals at Weyburn and North Battleford, and at the Training School in Moose Jaw.

Within the Department of Psychiatry at the University of Saskatchewan, the main research emphasis has been on sociological problems. These studies include evaluation of existing methods of organizing psychiatric services including follow up, and the role of the family doctor and of the public health nurse.

9. Conclusion

(i) Saskatchewan was the first Canadian Province to introduce "free" psychiatric treatment (1946).

(ii) Saskatchewan has a program of psychiatric research costing $250,000 annually.

(iii) Since 1947, in its mental institutions, Saskatchewan has had a three-year, 500-hour training program for psychiatric nurses.

(iv) In the Saskatchewan Plan, the Province has a program to build 150- to 200-bed regional psychiatric hospitals, which would serve areas with populations of 70,000-90,000 people.

(v) As an alternative to the small mental hospitals, or perhaps a variation of it, the staff of the Department of Psychiatry at the University of Saskatchewan are trying to develop a program by which all psychiatric hospital services in a community could be provided by that community's general hospitals.

REFERENCES

(1) Saskatchewan Division, Canadian Mental Health Association, *Ten Giant Steps, Strides in Mental Health.*
(2) Public Health Annual Report, Province of Saskatchewan, March 31, 1961.

(3) *The Saskatchewan Psychiatric Association,* brief submitted to the Royal Commission on Health Services, January 5, 1962.
(4) *The College of Physicians and Surgeons of Saskatchewan, Canadian Medical Association, Saskatchewan Division,* brief submitted to the Royal Commission on Health Services, January 22, 1962.
(5) *The Saskatchewan Association for Retarded Children,* brief submitted to the Royal Commission on Health Services, January 23, 1962.
(6) Annual Report of the Saskatchewan Hospital Services Plan, 1962.
(7) *The Canadian Mental Health Association, Saskatchewan Division,* brief submitted to the Royal Commission on Health Services, January 22, 1962.
(8) Aged and Long-Term Illness Survey Committee, Province of Saskatchewan, Report and Recommendation, July 1963.

CHAPTER 10

TRENDS IN PSYCHIATRIC CARE IN ALBERTA

1. Introduction (1) (2) (3)

In Alberta, the Minister of Health is officially responsible for the Province's Mental Health Program; his Deputy delegates administrative responsibility to Dr. R. R. MacLean, the Director of the Division of Mental Health, who is also the Government's advisor on mental health problems.

In addition to those who work in the Mental Health Division, many other people have much to do with Alberta's mental health problems. These include the administrators of general hospitals, non-psychiatric physicians in medical practice, and some who operate volunteer agencies and professional associations. Of those outside the Government interested in the care of the mentally disordered, many criticize the present situation and make suggestions for change. Most criticized is the legislation governing the admission of the mentally ill to mental hospital, and the lack of psychiatric hospital facilities in the southern part of the province.

Most critics give credit to the Government of Alberta for its efforts to improve the lot of the elderly mentally ill by setting up two Provincial Auxiliary Mental Hospitals; whatever the shortcomings of these institutions, they are better for the brain-damaged old people than are the huge mental hospitals where this type of patient is kept in most other provinces. The Government has also been justly praised for its education program for the nursing staff in its institutions, and for the Provincial Guidance Clinics.

One development in Alberta is unique in Canada—the Province has a eugenics program intended to control hereditary mental disorder by sterilization; during the past 35 years more than 2,000 people have been surgically sterilized on the recommendation of the Eugenics Board.

Another development of unusual interest in Alberta is its experimental unit at Red Deer for the treatment of emotionally disturbed children.

2. Provincial Psychiatric Services

(a) *Mental Hospitals* (1) (4)

Alberta has 4,780 patients in its five mental hospitals and two institutions for mental defectives. This gives the Province a ratio of 3.6 psychiatric beds per 1,000, for a total population of 1,313,000. This is close to the Canadian average of 3.8 beds per 1,000, and in excess of the 3 beds per 1,000 which the British

Government plans for in the United Kingdom. Of the Province's 4,780 psychiatric beds, 3,201 are in the five institutions for the mentally ill. Here the ratio of 2.4 beds per 1,000 for the mentally ill is above the 1.8 that the British have estimated as their maximum requirement.

In Alberta the five institutions for the mentally ill are:

Acute Mental Hospitals

(a) The Provincial Mental Hospital, Ponoka—1,052 patients

(b) The Provincial Mental Institute, Edmonton—1,410 patients

Chronic Mental Hospitals

(a) Rosehaven, Camrose—505 patients

(b) The Provincial Auxiliary Mental Hospital, Claresholm—105 patients

(c) The Provincial Auxiliary Mental Hospital, Raymond—129 patients.

The Provincial Mental Hospital at Ponoka was opened in 1911 as the first psychiatric institution in the Province. Because the public, 50 years ago, thought of the mentally ill as dangerous and disturbing, the "hospital for the insane" was placed in a country district, separate from any health facility and centrally located between Edmonton and Calgary. But today's concept of mental illness as being treatable and recoverable renders the isolated mental hospital as obsolete as the horse and buggy.

The Provincial Mental Institute at Edmonton is an acute treatment hospital for Edmonton and Northern Alberta. At one time it was known as the Oliver Mental Hospital, and was then used primarily for chronic patients. It has a 200-bed unit for the treatment of mentally disordered patients with tuberculosis. Whereas thirty years ago, nearly 10 per cent of all patients in the Provincial mental institutions suffered from tuberculosis, this number has since diminished so that now the 200-bed unit in Edmonton more than takes care of this group.

The two mental hospitals (along with the training school for mental defectives) have active training programs for nursing staff. At Ponoka there is a four-year training program which provides a girl that has the required high school credits with a combined qualification as a psychiatric and registered nurse; at present, there are a total of 45 students in all four years. The mental hospital at Ponoka also has a three-year course for male psychiatric nurses, and there is a similar three-year program at the Provincial Mental Institute at Edmonton for both male and female psychiatric nurses.

The three-year psychiatric nursing course provides 649 hours training; the graduates join the Alberta Psychiatric Nurses Association, which was founded in 1951 and incorporated under legislation enacted in 1955. This Association sponsors the Canadian Council for Psychiatric Nurses, which includes similar Associations from each of the three other Western provinces—British Columbia, Saskatchewan and Manitoba.

Uncertainty concerning the future of mental hospitals creates a dilemma for the psychiatric nurse today. If the mental hospital survives in its present form, then the prestige and security of the mental hospital-trained psychiatric nurse must increase; senior nursing positions in the institution should then be restricted to graduates from this course. On the other hand, if psychiatric hospital treatment is to be integrated with general hospital treatment, then the

psychiatric nurse of the future will likely be trained in a general hospital, and receive training similar to that given today to registered nurses with, of course, much more psychiatry. In Alberta, in addition to the training provided in the three-year course, the mental hospitals have six-months post-graduate training in psychiatry; this is open to selected Registered Nurses.

The Provincial mental hospitals are not well supplied with medical staff. According to the CMHA Brief to the Royal Commission, only 20 of the 32 established positions are now filled, and only 11 of these with certified specialists.

The critics of psychiatric services in Alberta point to the semi-isolation of the mental hospitals (particularly Ponoka), and to the distance from the population served; some patients have to travel up to 400 miles for psychiatric hospital care. Calgary, with a Metropolitan population of 250,000, has only 30 psychiatric beds in its hospitals; the remaining patients must go 120 miles to Ponoka.

The Executive of the Alberta Psychiatric Association has recommended the building of four regional psychiatric centers—each of 400 beds. These four centers would be located at Lethbridge, Calgary, Edmonton and Grande Prairie. The 400 beds will be divided into acute and chronic services of about 200 beds each. In addition to providing in-patient facilities, the centers would house out-patient treatment and consultation services. The Association has also recommended that all general hospitals of more than 100 beds have psychiatric units. It suggests that each of these units should contain at least 10 per cent of the total population of its parent hospital—with no unit having less than 15 patients.

(b) *Mental Deficiency* (4)

If two per cent of the population is mentally retarded, Alberta would then have more than 25,000 mental defectives at all levels. The Provincial Government now houses 1,567 mental defectives with 756 of these in the Provincial Training School at Red Deer, and 811 (mostly adults) in the custodial center called Deerhome—also at Red Deer.

Alberta was one of the first provinces to set up a program for the treatment of those mental defectives with phenylketonuria; it now has four children on the recognized therapy for this condition—a phenylalanine free diet; this costs the Province $450.00 per patient.

In its nursing course on mental deficiency, the Provincial Training School has 153 students.

(c) *Community Services* (4)

Having set up its first Provincial Guidance Service in 1929, Alberta now has four full-time and two part-time Provincial Guidance Clinics; it also has seven clinic teams, which travel from three of these centers to outlying places.

The full-time Guidance Clinics are at Edmonton, Calgary, Lethbridge, and Medicine Hat, with the most recent one at Medicine Hat being opened in 1961; on its team of workers, each clinic has a psychiatrist, a psychologist and a social worker with the number in each category depending on the volume of work—for example, the Edmonton Guidance Clinic employs a total of four psychiatrists. Besides the full-time clinics, there are part-time guidance services at Red Deer and at Ponoka—both operated by the staff of the local Provincial

institutions. The clinics offer consultation and treatment services, accepting referrals from public health units, from schools, from family doctors, and from parents.

3. Public Health (3)

As pointed out above, the Department of Public Health is responsible for the Province's mental health services. The Public Health Department comes under the jurisdiction of a Provincial Board of Health, with the Deputy Minister as one of three members (the other two being the Provincial Sanitary Engineer and the Provincial Bacteriologist). Of all of the Divisions of the Department of Public Health, the Mental Health Division, the Health Units, and the public health nurses have the most to do with the mentally disordered.

(a) *Mental Health Division*

I have already described the Division's activities within the Provincial mental institutions, and in the Guidance Clinics; the Mental Health Division also has an Eugenics Branch.

The principal body in this Branch is the Eugenics Board, which was formed in 1928 in an effort to control those mental disorders that resulted from hereditary causes. The Board has four members—two of whom are medical and two laymen; it meets every two months.

Since 1929, the Board has recommended sexual sterilization for more than 3,500 patients, and surgical operations for sterilization have been carried out on more than 2,000 patients.

To officially recommend sterilization necessitates the unanimous approval of all four members of the Board—plus the voluntary agreement of the patient, the parents, and the spouse; with retarded patients, the relatives' consent is not required. During 1961, sexual sterilization was recommended by the Board in 119 cases, and 104 operations were performed.

(b) *Health Units* (3)

Alberta has 24 public health units serving a population of 740,000, with all cities of more than 50,000 being excluded. Staffed by a Medical Officer of Health, public health nurses and other health personnel, these units were established primarily to prevent disease. The staff of the units are also interested in following up handicapped patients, yet as far as I could find out, very few discharged mental hospital patients are followed up by public health nurses. In Alberta, as elsewhere, this lack of professional staff, trained and organized to help the mentally disordered in the community is the greatest stumbling block to a good mental health program. The best chance of filling this gap seems to lie in the untapped potential of the dozens of public health nurses scattered throughout the Province; participating in an organized psychiatric program would be stimulating to most public health nurses if they had the training and the supervision—as well as the time.

4. Psychiatry in General Medical Services

(a) *General Hospitals* (5)

Alberta's 102 general hospitals have a total of 7,533 beds, making a ratio of 5.8 beds per 1,000 population. There are also 12 chronic hospitals, totalling 815

beds—a ratio of .6 beds per 1,000. If to this is added the 4,788 psychiatric beds, and the more than 1,000 beds in Federal institutions, the Province has a total of 14,147 hospital beds of all categories, with a ratio of 10.8 beds per 1,000.

To meet the needs of the chronically ill patients discharged from the general hospitals, the Government of Alberta builds institutions that it calls Provincial Auxiliary Hospitals; eligible for care in these institutions are those that cannot be looked after at home because of their need for medical and nursing care. Where closely attached to general hospitals, these chronic care units are a definite improvement over the old nursing homes; unfortunately, some are not attached to general hospitals.

Although not intended for the admission of chronically ill mental patients, the Provincial Auxiliary Hospitals do admit a few seniles from the surrounding areas. This is fortunate and should be expanded because many chronically ill patients have both physical and mental disabilities; moreover, integrating the care of the mentally ill and the physically ill in the same institution would reduce the stigma that has, for so many years, cursed the treatment of the long-term psychiatric patient.

The Government now has plans to increase the 815 beds for the chronically ill (.6 per 1,000) to 3,000 beds (about two beds per 1,000). In a Brief, jointly presented to the Royal Commission by (a) The College of Physicians and Surgeons, (b) The Alberta Division of the Canadian Medical Association, and (c) The Faculty of Medicine of the University of Alberta, it was suggested that the Government should increase the number of long-term beds to 2.5 per 1,000, or to a total of about 3,500 for the Province. When one compares this rate to the 1.3 per 1,000 long-term beds projected in Britain, it appears to be a disproportionate increase, unless it includes the care of such long-term mentally ill as the brain-damaged, a few schizophrenics needing continued care, and the severely mentally retarded.

The general hospitals in Alberta have been slow to develop psychiatric wards, the only units, at present, being in the University Hospital at Edmonton (60 beds) and in the Calgary General Hospital (30 beds). The unit in Calgary leaves much to be desired; it is in the basement, has grill-like windows, and while the ward itself is unlocked, the patients can be (and often are) locked up in single rooms.

Several individuals and groups in Alberta have recommended establishing more psychiatric wards in general hospitals, with the Alberta Psychiatric Association recommending units in all hospitals of more than 100 beds.

The Holy Cross Hospital at Calgary plans to add a 25-bed psychiatric unit, and the Foothills Hospital now being built in Calgary will have 75 psychiatric beds. The administrator of the Foothills Hospital plans to have some general practitioners admitting and treating their own patients in the 75-bed psychiatric unit.

In Edmonton, the Misericordia Hospital will establish a 25-bed ward in this 500-bed institution; here also the general practitioners will admit and treat their own psychiatric patients. If the present plan holds, the general practitioners of the Misericordia will be graded in psychiatry as they now are in medicine, surgery, and in other specialties, and they will be allowed to treat patients in the psychiatric unit according to their level of competence—as recorded in this grading.

How will changing trends affect the organization of psychiatry in Alberta? Will the Government concentrate on improving the present large institutions, or will it build 400-bed regional psychiatric centers as proposed by the Alberta Psychiatric Association, or will it attempt to provide psychiatric services in and around its general hospitals? Each proposal has its advocates, with the latter proposal favoured by some of the general hospital administrators. Psychiatry based on general hospitals could only succeed if the Government continued to build Auxiliary Hospitals and permitted the direct admission of brain-damaged old people to these units.

(b) *General Practitioners* (5)

Eight hundred and sixteen of Alberta's 1,331 practising physicians are listed as general practitioners, which works out to one general practitioner for each 1,600 population.

In Alberta, as elsewhere, most people fail to recognize the extent of the general practitioners' contribution in the diagnosis and treatment of psychiatric conditions. This omission occurs partly because the general practitioners themselves are reluctant to admit that they spend much of their time treating the anxieties of their patients; the traditional isolation of the psychiatrist from other physicians also obscures what the general practitioners do in psychiatry.

Understandably, general practitioners and psychiatrists in Alberta (as elsewhere) criticize each other frequently. The general practitioner says that the psychiatrist does not give him enough help with his psychiatric emergencies; he also complains of the lack of facilities outside of mental hospital for the treatment of the mild psychiatric disorders. Psychiatrists criticize the way some general practitioners handle the anxiety disorders of some of their patients; they also think that even though general practitioners have to deal with many psychiatric disorders, that they display a lack of interest in the psychiatric problems of their patients. They believe that general practitioners try to turn over to psychiatrists many psychiatric patients that they could better handle themselves. In reply to this, some Alberta general practitioners told me that they only referred patients if frustrated through the lack of progress, or if they found themselves out of their depth.

Yet there is some indication in Alberta of a slowly developing recognition of the need for the general practitioners to play a larger part in the treatment of psychiatric disorders—particularly in anxiety reactions. As evidence of this, at least two hospital administrators told me that they wished to have general practitioners admitting and treating psychiatric patients on the psychiatric service of their general hospitals. In providing future psychiatric hospital care, perhaps better leadership could come from hospital administrators than from either general physicians or from psychiatrists.

5. The Canadian Mental Health Association (6) (7)

Organized in 1954, the Alberta Division of the Canadian Mental Health Association now has 20,000 paid-up members. Although its Executive officially represents the membership of the entire Province, unofficially the Division follows the Alberta tendency to split into northern and southern sections.

The Association set forth its policies in its Brief to the Royal Commission on Health Services; the aims of the Division include (a) supporting the principle of integrating psychiatric services with other medical services, (b) enlisting

community support towards improving psychiatric services, (c) developing local psychiatric facilities, and (d) supporting psychiatric research.

The Alberta Division has accepted one important service commitment—operating White Cross Centers at Edmonton and Calgary; besides providing fellowship and recreation, these units aid in the rehabilitation of mentally disordered persons.

6. Special Items

(a) *Child Psychiatry* (4)

The out-patient services provided in Alberta for mentally disordered children are much better than the Province's in-patient facilities for this group. The Provincial Government has established full-time child guidance services at Edmonton, Calgary, Lethbridge, and Medicine Hat, with part-time services at Red Deer and Ponoka. In most centers, the child guidance services are linked with the adult psychiatric services, but in Edmonton and Calgary several members of the clinic teams work only with children.

Besides the stationary clinics, there are three travelling guidance teams (staffed with psychiatrists, psychologists and social workers) which make scheduled visits to outlying points to see disturbed children.

A glance at the 1960 statistics of the guidance clinics affords some indication of the kind of problems dealt with, and by whom these are referred. Of the 1,639 new cases, 495 were classed as educational difficulties, with 436 as problems of emotional disturbance. The schools refer 25 per cent, parents 15 per cent, and the social agencies refer another 12 per cent of the total seen.

In-patient facilities are less adequate than out-patient services. At the time of the visit by the Royal Commission on Health Services to Alberta in 1962, there were but two in-patient units with a total bed capacity of 28. One of these was an 8-bed ward within the Department of Paediatrics in the University Hospital, Edmonton, operated by Dr. Keith Yonge and his staff from the Department of Psychiatry. The other was a 20-bed unit called Linden House, located in Red Deer; Dr. MacLean established it as a pilot project for the treatment of disturbed children. Many interested individuals and organizations have studied the need for more services in Alberta for mentally disturbed children, and have recommended improvements. These requests for change have come from such diverse groups as the Scientific Planning Committee of the Alberta Division of the Canadian Mental Health Association, and from the College of Physicians and Surgeons.

Most observers praise the existing child guidance clinics, and recommend that these be expanded; the Brief of the College of Physicians and Surgeons recommended increasing the guidance teams in the Province from 7 to 25.

There are even louder demands to expand in-patient facilities for emotionally disturbed children. Most requests are for 150 to 200 beds divided between the northern and southern regions. Most recommend units for short-term observation and long-term treatment, as well as special units for the diagnosis and treatment of emotional disorders of adolescents.

(b) *The Aged* (3)

There are more than 125,000 people in Alberta over the age of 65. For those prevented by social or economic reasons from living at home, the Province has a

total of 2,500 beds in 50 homes for the aged; the staff in most of these homes cannot look after residents with severe chronic illness—especially those with mental disorder.

In its auxiliary hospitals for chronic disease, the Provincial Government provides chronic hospital care for nearly 800 older persons who have chronic physical illness; the authorities do not encourage admission to these units of patients suffering from senile dementia. Where separated from acute general hospitals, these chronic hospital units are handicapped by a lack of specialized medical and surgical facilities, and by limited contact with practising physicians.

In its Rosehaven unit, and at the Provincial Auxiliary Mental Hospitals at Claresholm and at Raymond, the Province looks after nearly 700 old people with mental disorder. Such units appear to provide better care for the elderly psychotic than he could receive in the Provincial Mental Hospital, but they too have their shortcomings; here the psychotic old person is still remote from his home community, from his family, and his family physician. Moreover, these brain-damaged old people have many serious mental and physical disorders, yet being apart from hospitals where acute illness is treated, they do not have the daily supervision of qualified consultants in medicine, surgery and psychiatry.

The Government of Alberta plans to triple the number of beds provided in the auxiliary (chronic) hospitals, and the Provincial College of Physicians and Surgeons wants an even larger increase. Although these proposed units are not intended for the admission of psychotics, it would seem wise to build the auxiliary hospitals as extensions to general hospitals, and to permit the admission of brain-damaged old people. Since the diagnosis and treatment of the psychoses of the aged is becoming a much greater problem in the community, the skill of the family doctor would be increased if, in collaboration with psychiatrists, he could treat his senile patients in these auxiliary hospitals; this would also maintain continuity in care.

The problems in looking after the increasing number of confused old people cannot be solved by their removal from the regular medical facilities, nor by isolating them in separate institutions. During discussions with several hospital administrators in Alberta, we considered the possibility of getting help with the confused old from general hospitals. Most of the administrators thought that psychiatrists, internists and general practitioners should set up pilot projects on psychogeriatrics in general hospitals. Nobody knows how many hospital beds would be required if first-class treatment facilities were available both in hospitals and in the community; only a carefully evaluated pilot project would provide the answer. Because housing and finance complicate the medical problems of old people, welfare authorities should participate with health officers on any project on caring for the confused elderly.

(c) *Rehabilitation*

Like other Provinces, Alberta has done too little about the rehabilitation of the mentally sick. The three sheltered workshops in the Province are for physically handicapped, and used only incidentally for convalescent psychotics. Outside of the Government Service, the most effective rehabilitation is undertaken by the White Cross Centers of CMHA, which were originally meant for recreation rather than occupation.

Programs for rehabilitating the physically ill should be expanded to meet the needs of the mentally disordered. Funds from the Federal Rehabilitation Grant should be used to train psychiatric nurses and physicians in rehabilitation.

Sheltered workshops should be expanded to provide training and occupation for the retarded, for schizophrenics, and even for some brain-damaged persons.

(d) *Alcoholism*

According to Jellinek's generally accepted formula, Alberta has more than 12,000 alcoholics. These people are the concern of the Alcoholism Foundation which has branches in Edmonton and Calgary. The organization also sends travelling clinics to outlying centers. Most of its funds come from Provincial Government Grants.

In Edmonton, there is a unit for the treatment of alcoholics serving sentence. Few general hospitals encourage the admission of alcoholics for treatment, although some do. One Sisters' hospital has staff specially trained to deal with patients in the throes of acute alcoholism.

(e) *Forensic Psychiatry*

As in other provinces, in Alberta mentally disordered persons charged with or convicted of crimes present the psychiatrists with a serious dilemma. As a carry-over from when a mental institution was thought to be a bizarre variation of a prison, magistrates and judges still send to mental hospital mentally disordered persons charged or convicted of crimes. Hence it becomes more difficult to open the mental hospital doors, or to keep psychiatric units open in general hospitals.

Some of the Provincial Authorities in Alberta want the Federal Government to establish a security unit for the treatment of mental patients charged or convicted of crime, or found not guilty because of insanity.

(f) *Legislation Governing Admission to Mental Hospital* (8) (9)

At the present time, a patient may be admitted to a Provincial mental institution in one of three ways: (1) voluntarily, (2) by medical certificate, or (3) committal by a police magistrate.

If admission by a medical certificate is sought, the superintendent of the mental hospital, after approving the physician's certificate, asks a magistrate or judge to issue a warrant directing that patient's transfer to his institution.

When a magistrate is petitioned to have a patient committed as "mentally diseased and dangerous to be at large" he first hears medical evidence. If, in the course of this inquiry, it becomes necessary to delay proceedings, the magistrate commits the patient to a place of safekeeping—a place of safekeeping could even be a jail or a police cell.

For the past two years, a committee of 14 persons has been preparing a new Act embodying present day concepts.

(g) *Private Practice* (4)

Alberta has 18 psychiatrists in private practice; 8 of these are in Calgary and 10 in Edmonton (4 of the Edmonton group are in part-time private practice).

A prepaid physician-sponsored plan (The Medical Services Incorporated) deals generously with the claims made for payment for psychiatric treatment. MSI will honour claims up to $1,000 for one patient annually (paying 90 per cent

of the schedule). The rate for initial psychiatric examination is $25.00, and for psychotherapy $15.00 an hour—with a $10.00 minimum. The agency pays $5.00 for group therapy and for electroconvulsive therapy $10.00 for each of the first five treatments for one patient, with $5.00 thereafter.

Private psychiatrists do have a great deal of difficulty getting hospital beds for their patients. This is especially true in Calgary where there are but 30 beds for a population of 250,000.

(h) *Social Work*

As in other Provinces, the lack of qualified workers to follow up discharged psychiatric patients creates a serious bottleneck in providing psychiatric care. Of 93 qualified social workers in the Province, only 6 are engaged full-time in psychiatry—3 in the Provincial clinics, 2 in the University of Alberta.

The staff of such units as the Catholic and Family Service Bureaus, the Children's Aid Department, Probation Departments, the John Howard Society and others, do much social work with psychiatric patients, but it is evident that the attempts made by all of these groups to deal with psychiatric problems are not co-ordinated, and presumably not nearly as effective as they might be.

The staffs of the Provincial Mental Hospitals at Edmonton and Ponoka, and of the institutions for the Mentally Retarded at Red Deer carry a heavy follow-up load; they are handicapped by distance from patients' homes, and by a shortage of trained workers.

If the mentally disordered in the community (and their families) are to receive the help needed, there must be enough trained persons throughout the Province to carry out this follow up. Obviously, in the future there could not be enough trained social workers to do this properly. However, trained workers could assist the public health nurses to organize follow-up services, which could be used by general practitioners, consultant psychiatrists, general hospital staff, and by the local authorities. Chances of providing better social services would be increased if the University of Alberta had a School of Social Work.

7. Conclusion

(i) The Province of Alberta has gone much further than most in devising new facilities outside of mental hospital for the confused elderly; these are the Provincial Auxiliary Mental Hospitals. The Government also has a program for building Provincial Auxiliary Hospitals for long-term physically ill—with more coming; if it allies these units closely with the general hospitals, and permits the admission of psychiatrically ill old people, then the Province of Alberta might well take a long lead in improving the care of the increasing number of confused aged persons.

(ii) Alberta nas nearly a score of private practitioners of psychiatry, many of whom have been actively interested in improving patterns of psychiatric care; Alberta's voluntary associations for the prepayment of medical care provide excellent coverage for psychiatric disorders.

(iii) The mental hospitals operate an effective psychiatric nurse training program, which has provided a high ratio of trained nursing staff.

(iv) The Alberta Division of the Canadian Psychiatric Association has proposed the building of 400-bed regional psychiatric centers with the

hope that these might ultimately replace the large mental hospitals. Such a center built as a pilot project would produce much useful information to guide future developments in psychiatric care.

(v) The Province of Alberta has had Canada's most active program for the control of mental disorder through legislation on eugenics; as a result of recommendations made by the Eugenics Board, during the past 30 years, more than 2,000 mentally disordered persons have been sterilized.

(vi) The province has an active program for dealing with the problems of alcoholism; this is run by a Foundation with the support of the Provincial Government.

(vii) In the opinion of the author of this study, there is great need for study and change in the legislation for the admission of mentally disordered persons to Provincial institutions in this Province.

REFERENCES

(1) Mental Health Services, Alberta Department of Public Health, 1961.
(2) Annual Report of the Department of Public Health, Alberta, 1961.
(3) *The Government of the Province of Alberta,* brief submitted to the Royal Commission on Health Services, February 1962.
(4) *The Alberta Psychiatric Association,* brief submitted to the Royal Commission on Health Services, January 1962.
(5) *The Alberta College of Physicians and Surgeons, Canadian Medical Association, Alberta Division and the Faculty of Medicine,* joint brief submitted to the Royal Commission on Health Services, February 1962.
(6) *The Alberta Division of the Canadian Mental Health Association,* brief submitted to the Royal Commission on Health Services, February 1962.
(7) *The Southern Alberta Region, Canadian Mental Health Association,* brief submitted to the Royal Commission on Health Services, February 1962.
(8) Chapter 200, *The Mental Diseases Act,* Alberta.
(9) Chapter 191, *An Act Respecting Mentally Defective Persons,* Alberta.

CHAPTER 11

TRENDS IN PSYCHIATRIC CARE IN BRITISH COLUMBIA

1. Introduction (1)

Some of British Columbia's unusual topographical characteristics are reflected in its psychiatric service. Nearly half of its 1,600,000 population lives in the built-up area that surrounds Vancouver and New Westminster, and as a result, most of the psychiatric services are concentrated in this same area; most of the psychiatric services in the Vancouver area that are financed by the Provincial Government are actually located on the grounds of the Provincial Mental Hospital at Essondale. This puts the Provincial psychiatric services within easy reach of half of the Province's population, but for the rest of the population, psychotic patients requiring hospital care face a difficult trip—sometimes more than 500 miles.

Vancouver is also the site of the Province's only medical school, which, for undergraduate psychiatric teaching, for the most part, uses the psychiatric facilities of the Vancouver General Hospital, and of the Shaughnessy DVA Hospital. As in some other parts of Canada, on the question of what constitutes the most desirable plan for future psychiatric care, those responsible for teaching psychiatry in the Province's medical school sometimes disagree sharply with those responsible for Provincial psychiatric services.

Because of the Province's usually buoyant economy, leaders in British Columbia psychiatry usually have had more money to spend than their counterparts in other provinces; British Columbia has been fortunate in having such dedicated leaders as Dr. A. L. Crease, Dr. Arthur Gee, and its present Director of Mental Health Services, Dr. A. E. Davidson. For these reasons, the physical facilities at Essondale have usually compared favourably with those in mental hospitals in other parts of the country; moreover, the staff-patient ratios have been high, and the staff-training programs and occupational facilities well above average. To some extent this heavy investment in buildings and in equipment at Essondale has handicapped the present leaders in their efforts to decentralize services, and to develop treatment programs in general hospitals. The actual provincial expenditure on its psychiatric commitments in 1960 was $15,409,000—a robust figure in comparison with most other provinces; during that year, British Columbia received a Federal Mental Health Grant of $790,742.

British Columbia's 6,247 psychiatric beds (including beds for the mentally retarded) make up about 32 per cent of all hospital beds in the Province. Even though the per diem cost of $5.21 for mental hospital beds is one of the highest in Canada, it is significantly lower than the $17.56 per diem cost in the Province's

general hospitals during the same year. All this shows that Dr. Davidson and his colleagues face a difficult task in their efforts to bring psychiatric care up to the same standards as other medical care in the Province. Psychiatry in British Columbia is cursed with the same burden of prejudice, ignorance and hostility, as is found in other Canadian provinces.

In one respect, provincial psychiatric services in British Columbia are organized differently than in most other provinces—they do not come under the Deputy Minister of Health. The Mental Health Services Branch is one of the responsibilities of the Minister of Health Services and Hospital Insurance; he delegates operational authority to the Director of the Mental Health Services Branch, who has Deputy Minister status. This differs from the other nine provinces in which the Director of Mental Health is responsible to the Deputy Minister of Health. It has always been hoped that if psychiatry were administered with other health services, this would help in the integration of psychiatric care with general medicine, and, as a result, would interest non-psychiatric health personnel in mental health problems. Most observers now think that this anticipated result has not materialized; having Directors of Mental Health responsible to Deputy Ministers of Health has, in the opinion of many, impeded rather than helped the development of psychiatric services. It is my opinion that the British Columbia policy of giving Deputy Minister status to the Director of Psychiatric Services is the better plan. It may be that complete integration of psychiatric services into other medical services will eventually do away with the need for a Psychiatric Services Branch, but until that day comes, it will probably be best for its chief to be directly responsible to the Minister.

The Mental Health Services Branch, under the direction of the Deputy Minister of Mental Health Services, has five Divisions. These are (1) The Geriatrics Division administering units for the aged psychotics hospitalized at Essondale, Terrace and Vernon, (2) a Division which administers schools for mental defectives at New Westminster and at Tranquille, (3) The Mental Hospital Division which administers the Crease Clinic and the Provincial Mental Hospital at Essondale, and the Provincial Mental Home at Colquitz (to be abandoned), (4) Community Services Division administering the Mental Health Center at Burnaby, the Mental Health Centers at Victoria and another center being developed at Kelowna, (5) The Division of Nursing Education.

2. Provincial Mental Health Services

(a) *Mental Hospitals* (3)

Of the Province's 6,247 beds for patients with psychiatric disorder, 4,751 are for psychotics. These are located in six institutions:

(i)	The Crease Clinic of Psychological Medicine	265 beds
(ii)	Provincial Mental Hospital, Essondale	3,019 beds
(iii)	Provincial Mental Home, Colquitz	288 beds
(iv)	Valleyview Hospital, Essondale	657 beds
(v)	Dellview Hospital, Vernon	234 beds
(vi)	Skeenaview Hospital, Terrace	288 beds

Located on the grounds of the Provincial Mental Hospital at Essondale, the Crease Clinic is a small hospital unit, opened in 1948 to treat most of the Province's acute psychotics; it was hoped that only the chronic patients would be committed to the main mental hospital. With this in mind, a special Act was passed that enabled the Crease Clinic to admit patients either voluntarily, or on

two physicians' certificates with the provision that these patients not remain in the Crease Clinic longer than four months.

In contrast to patients admitted to the Provincial Mental Hospital, patients admitted under this Act are held without the authority of a judge. The Crease Clinic has worked out about as anticipated. Approximately 1,000 new patients are admitted each year (compared to 700 to the Provincial Mental Hospital); less than 100 have to be transferred each year to the mental hospital (after a four-month stay).

The 3,000-bed Provincial Mental Hospital at Essondale admits patients not considered eligible for the Crease Clinic; it does not accept patients over 70 years of age. Understandably, its patients are more likely to be chronically ill than those in the Crease Clinic, and to stay for longer periods of time; 75 per cent of its present population has been in hospital for more than two years.

Together with the Crease Clinic, the Hospital has a staff of more than 800 graduate psychiatric nurses, and more than 200 students in psychiatric nurse training. As a result, the ratio of trained staff to patients in the institution is as high as in any mental hospital in Canada.

There are more than 1,100 aged psychotics in the three Provincial homes for aged and senile patients. One of these institutions is on the grounds of the Provincial Mental Hospital at Essondale; one of the other two is located in Northern B.C.—at Terrace, and the other in the eastern part of the Province—at Vernon; thus most of the older mental patients are looked after nearer to their own homes than are the younger psychotics.

More than any other province, British Columbia admits the aged and seniles directly to separate institutions rather than to mental hospital; although, as a result of this, the aged are treated nearer home than are the other psychotics, yet the psychotic old people are thus isolated from the rest of psychiatry and from the rest of medicine. One wonders whether under this arrangement the aged psychotic can receive the intensive physical and psychiatric care that he would get if he were admitted to a Provincial Mental Hospital or, preferably, to a psychiatric unit in a general hospital. Actually, there is little turnover in the three institutions with vacancies being created as often by death as by discharge.

(b) *Mental Retardation* (4) (5)

If one accepts the statement of the Canadian Association for Retarded Children that 3 per cent of the population is mentally retarded, then British Columbia has 45,000 retarded persons (if the more conservative 2 per cent criterion is accepted, then the number is 30,000). The Mental Health Services Branch looks after 1,398 retarded persons at the Woodlands School at New Westminster, and another 173 at a school in a former tuberculosis treatment building at Tranquille. Like their counterparts in other provinces, these institutions are somewhat euphemistically called schools; although they do have educational programs, they are more and more becoming repositories for severely retarded, severely handicapped, mental defectives. The Woodlands School provides one somewhat unique and much appreciated service by accepting some retarded children for short periods so that their parents may have a holiday; during 1961, more than 100 children were admitted in this manner for periods averaging up to 30 days.

The Woodlands School also provides travelling diagnostic clinics staffed by psychiatrists, psychologists, and social workers, all of whom act as consultants to family physicians and social agencies on problems of mental deficiency.

Subjected to the dissident voices of dissatisfied parents, British Columbia, like other provinces, has been influenced by demands for changes in its way of looking after the mentally retarded. During the past 10 years, 44 day schools for retarded pupils have been established—mostly for those with middle-grade retardation—living at home; 36 of these schools are operated by parents' groups, with the remainder by school boards.

Parents today demand more and better decentralized services. It would seem that as soon as the State will accept responsibility for educating the retarded child, in the same way as it now does for educating normal children, most school boards will provide facilities for the middle-grade as well as for the high-grade defective; for low-grade defectives, municipalities backed by Provincial Governments will then have to establish residential units near the parental homes. Now that the parents are in full cry, it is unlikely that they will stop their demands until more has been done to provide sheltered workshops for those who are too retarded to compete in the ordinary labour market. They will also insist on local hostels for mental defectives able to stay in the community, but unable to live at home. Some of these trends will be described in the section on the B.C. Association for Retarded Children.

(c) *Community Psychiatric Services* (6)

The Provincial Government operates units called Mental Health Centers at Burnaby and Victoria, and is setting up a similar center in Kelowna. For the most part, these centers are full-time mental health clinics with day care added. They provide consultation services to doctors and agencies for both children and adults. In areas away from the Lower Mainland, these centers in future are likely to have beds available—either in the centers themselves or in nearby general hospitals.

The Province operates travelling clinics, which hold sessions at 26 Mainland points, and at 5 places on the Island. These provide consultation services to local physicians and agencies. The Government is also planning an after-care unit to follow up discharged patients in downtown Vancouver. Besides these Government-operated psychiatric facilities, Vancouver also has the Mental Hygiene Division of the Metropolitan Health Committee in Greater Vancouver, and an out-patient department for adults and children as part of the Vancouver General Hospital.

The need to provide Government-sponsored clinics for consultation and treatment points up the inadequate way in which organized medicine handles psychiatric problems. Although the present situation is much better than no consultation services at all, the overworked Government psychiatrists are not able to provide adequate coverage for all the doctors and agencies needing advice. Proper consultation service will only become possible once psychiatry is accepted in the same way as are other medical specialties.

3. Psychiatry in General Medical Services

(a) *Psychiatry in General Hospitals* (7)

Not counting the 50 psychiatric beds in the Shaughnessy DVA Hospital, in 1961, only 62 of British Columbia's nearly 10,000 general hospital beds are for

psychiatric patients. These beds are in two units—one a 40-bed ward at the Vancouver General Hospital, and the other a 24-bed ward at the Royal Jubilee Hospital in Victoria. Even though only 62 of more than 6,000 psychiatric beds are in general hospitals, these two units account for more than a third of the total psychiatric admissions in the Province. The per diem cost for beds in general hospitals is nearly $18.00, which is about three times the cost in the Provincial Mental Hospitals.

The lack of psychiatric beds in British Columbia general hospitals prolongs the separation of psychiatric care from other medical care. More units in general hospitals would result in more experience in psychiatry for all doctors and nurses. Since all non-psychiatric physicians and nurses see large numbers of psychiatric patients, they need the instruction that psychiatric services in general hospitals would provide; yet I saw no evidence in British Columbia of any vigorous trend towards replacing mental hospital beds with units in general hospitals. It would seem advisable to establish psychiatric services as pilot projects in several British Columbia general hospitals; in only this way can the true place of psychiatric units in general hospitals in this Province be precisely determined.

(b) *Non-psychiatric Physicians* (7) (8) (9)

British Columbia has one doctor for each 810 population—compared to one to 880 in the whole of Canada giving it the highest ratio. The ratio of general practitioners is lower in British Columbia (undoubtedly due to the concentration of urban population in Vancouver) with one general practitioner for each 2,050 population—compared to one to 1,777 in the rest of Canada.

As in the rest of Canada, British Columbia's general practitioners and internists (as well as most of the other specialists) encounter large numbers of emotionally disturbed patients. Like doctors elsewhere, they complain that they are ill-equipped to handle the problems of these patients, and that they receive inadequate support from consulting psychiatrists. The general practitioners in British Columbia often cannot get help from a psychiatrist when they need it. The psychiatrist is frequently just not available to help with the emergency patient in an acute psychotic disturbance. When the general practitioner seeks help with the less disturbed psychiatric patient, he says that it often takes weeks to get an appointment with a psychiatrist. Often he does not see the patient again, or does not hear what the psychiatrist decided about the illness. Frequently the patient comes back no better than before, and so the general practitioner remains no wiser. Many general practitioners with whom I talked in British Columbia asked why the psychiatrist could not give the same kind of emergency service, as do consultants in surgery and in medicine.

One problem seems to lie in the family doctor's failure to realize that he must be equipped to do most of his psychiatry himself. Moreover, most psychiatrists do not limit themselves to acting as consultants, but rather become involved in long-term treatment of patients referred to them; thus usually they end up acting as general practitioners in psychiatry, and have less time available for prompt consultation service.

The policy of the physician-sponsored prepayment scheme in British Columbia makes it possible for the family doctor to be paid for treating

psychiatric patients just as he is for other patients; he charges $5.00 for the first, and $4.00 for subsequent visits.

If the general physician is to treat confused and depressed people, he should have the privilege of admitting psychiatric patients to general hospitals. Fortunately the undergraduate training at the University of British Columbia now gives the new crop of doctors better preparation for looking after their psychiatric patients.

4. Voluntary Associations

(a) *Canadian Mental Health Association* (10)

The British Columbia Division of the Canadian Mental Health Association has played an active part in moulding public opinion to demand a different pattern of psychiatric care. The Executive of the Association has campaigned to have the control of psychiatric facilities placed under local boards—with financial support from the Provincial Government. The Association has recommended psychiatric units in all general hospitals, with more out-patient facilities being made available. Besides taking steps to change public opinion, the Association has provided the Provincial Mental Hospital at Essondale with an active group of volunteer visitors.

(b) *The British Columbia Association for Retarded Children* (5)

The British Columbia Division of the Canadian Association for Retarded Children has 51 branches and committees. It has established and is administering a number of day schools and other units to help the mentally retarded. There are now 36 day schools under the direct guidance of the CARC. In addition, there are three sheltered workshops, one occupational center, one day-care center, and one hostel. Besides this, the Association deserves some credit for the success of the eight day schools operated by local school boards.

The goal of the British Columbia Division of the CARC is to bring about a better deal for the mentally retarded through public education and pressure on Government. These objectives include a hope that the Government will spend much more money to increase such services as diagnostic clinics, home counselling visitors, classrooms operated by school boards, more sheltered workshops and hostels. The Association would like to see the severely retarded kept in small local units, rather than in large central facilities like Woodlands.

5. Special Items

(a) *Child Psychiatry*

British Columbia has meager facilities for the diagnosis and treatment of emotional and behaviour disorders in children. The Provincial Government operates a psychiatric program for children, which only scratches the surface of this problem; this Government service is supplemented by some private facilities in the City of Vancouver.

The Mental Health Centers at Burnaby, Victoria—and now Kelowna—provide consultation and limited treatment services for children with psychiatric problems. The staff of the travelling clinics see disturbed children, and give advice to local physicians and to social workers.

In the City of Vancouver, the Division of Mental Hygiene of the Metropolitan Health Committee has a consultation and treatment program for the school population of Greater Vancouver. Its staff includes 2 psychiatrists, 4 psychologists, 5 social workers, and assistance from 150 public health nurses. The staff members of these clinics see about 500 new patients annually, and carry about 100 in treatment.

Vancouver has a lone private unit called the Esther Irwin Home, which can accommodate a total of 15 children for the treatment of emotional disorders. These children range in age from 6 to 12 years, and can remain in the home for periods of from 4 months to 2 years.

British Columbia lacks the facilities to train psychiatrists, psychologists and social workers to help the family doctors and school teachers deal with emotionally disturbed children. There is a need for a joint facility for research and for teaching at the University, that would involve child psychiatrists, paediatricians, and staff from the Department of Education.

(b) *The Aged* (11)

Because of its milder climate, British Columbia has become a Mecca for older people; of its population, 10.8 per cent is now over the age of 65—the highest proportion of this age group in any Canadian province. With its older population, the Province has more elderly psychotics to look after than has any other province.

The Provincial Government has dealt with the problem of the elderly psychotic by setting up homes for the aged and senile at Essondale, Terrace, and Vernon; these have a combined accommodation of more than 1,300. Since demands exceed the available beds, commitments to these Homes must be approved by their Superintendent before the patient is brought in.

Although having hospitals for aged and senile patients may result in these patients being cared for nearer their own homes, in my opinion, the plan has one real disadvantage; it separates these patients (many of whom are severely ill—physically and mentally) from the facilities and staff of the most active psychiatric and medical services. The most severely handicapped of these aged and senile persons would receive the best standard of care in wings of general hospitals where more intensive medical and nursing treatment services are available.

(c) *Rehabilitation*

In British Columbia, the Mental Health Services Branch rehabilitates some patients through a boarding home program; these boarding homes receive a total of more than 100 persons each year from the Crease Clinic and from the Provincial Mental Hospital. Two half-way houses, strikingly named Vista and Venture, serve as way stations, and each year about 100 patients in the course of their rehabilitation pass through these units.

The greatest handicap in the rehabilitation of mental patients is in the lack of suitable employment. Unpaid occupation in mental hospitals has some therapeutic advantages, but, on a long-term basis, does not present an attractive prospect. Psychiatrists in British Columbia could benefit from the experience in the United Kingdom. Thanks to the buoyant economy and to the high level of employment now in Britain, the British mental hospitals can provide paid work

for mental patients both in hospital and in the community; so far no Canadian hospital has been able to do this. In British Columbia, as elsewhere in Canada, the mentally handicapped, who cannot produce up to a minimum standard, are maintained in Government hospitals in unpaid idleness; obviously, this swells the number of hospital beds, and accounts for many of the more than 6,000 patients in Provincial psychiatric institutions.

Sheltered workshops should be established as pilot projects to explore ways of meeting Union objections to subsidized employment, and to ascertain how far such programs would cut down the number of hospital beds. Banking partly on the effects of sheltered employment, the British hope to reduce their mental hospital population from 3 per 1,000 to 1.8 per 1,000 during the next ten years; Canadians would do well to have a similar objective. But such progress in rehabilitation will not be possible without sheltered employment, and an increase in the number of trained staff working in the community with discharged patients.

(d) *Addiction* (12)

In addition to having an active organization that deals with acute alcoholics, and provides public education on alcoholism, British Columbia has a Narcotic Addiction Foundation. It is estimated that half of Canada's 4,000 narcotic addicts live in Vancouver. The Narcotic Addiction Foundation was established because of the need to assist those who voluntarily seek help. In its downtown quarters, the staff of this private organization provides out-patient advice, and admits some in-patients who request help during withdrawal; all of this is carried out on a voluntary basis.

Nonetheless, the total needs of neither the alcoholics nor of the addicts are, as yet, adequately met. Many think that general hospitals should have units for the treatment of acute alcoholics and for the withdrawal problems of the narcotic addict. It would seem wise to set up pilot projects in one or two of Vancouver's general hospitals to seek better methods of helping both alcoholics and narcotic addicts.

(e) *Legislation* (13)

The laws governing psychiatric care in British Columbia range from the obsolete to the modern. By the Mental Hospitals Act now in operation, judges or magistrates must participate in compulsory admission of patients to Provincial Mental Hospitals. The Clinics of Psychological Medicine Act softens this provision by authorizing, for periods up to four months, the detention of patients admitted on two doctors' certificates to the Crease Clinic. The Provincial Mental Health Centers Act provides legislation for the centers at Burnaby, Victoria, Kelowna, and for other centers yet to come. Finally, the Schools for Mental Defectives Act legislates for the mentally retarded; this last Act could well be brought up-to-date in the light of recent developments in the care of the mentally retarded.

The main criticism against the present legislation is that it helps perpetuate the image of the mentally disordered as being violent people who are "dangerous to be at large". True, there is authority for the voluntary admission of patients, but this does not apply to mental defectives. Most disturbing is a provision by which, under certain circumstances, patients thought to be mentally ill (but not charged with crime) may, pending disposal, be detained in jail.

It would seem that the legislation concerning the mentally disordered in British Columbia should be reviewed and changed in line with modern concepts; such a step was taken in Britain in 1959 in the new Mental Health Act. The practice of admitting to the Provincial Mental Hospitals patients accused or convicted of crime should be reviewed. These patients now are transferred from jails and penitentiaries on orders from the Lieutenant-Governor in Council; their presence in psychiatric units is detrimental to other mentally disordered patients.

(f) *Private Practice of Psychiatry*

Because of the large urban population in the City of Vancouver, British Columbia has a higher proportion of psychiatrists in private practice than have most other provinces; it also has a 36-bed private psychiatric hospital at New Westminster. This active group of private practitioners in psychiatry does provide Vancouver's general practitioners with a good deal of consultation assistance. Nonetheless, general practitioners and other physicians need much more back-up help of this sort.

Since both psychiatrists in private practice, and psychiatrists employed by the Provincial Government provide similar diagnostic consultation services, and comparable treatment services, one wonders whether the methods of paying both groups should not be more alike than now is the case; could not both groups of psychiatrists receive basic stipends for participating in community psychiatry, and both do private practice as well?

(g) *Social Workers*

British Columbia has 71 qualified social workers employed in its Mental Health Services; another 34 medical social workers (employed in general hospitals in Vancouver and in Victoria) frequently encounter patients with psychiatric problems. Of the psychiatric social workers, 29 work in mental hospitals, 3 in geriatric units, 8 in schools for mental defectives, and 31 in community psychiatric services. Eight medical social workers are employed with school health services and one is with the Canadian Mental Health Association.

Due to the recent increase in the number of psychiatric patients being treated in the community, and to the shorter stay of patients in psychiatric hospitals, the Province of British Columbia requires a comparable increase in the number of persons employed in the community to give assistance and advice to these patients and to their families; but so far comparable increases in the number of fully qualified social workers seems most unlikely. Could not the present cadre of trained and experienced psychiatric social workers be more profitably employed by being used less as case workers and more as consultants to other community workers such as public health nurses and semi-trained home visitors? Both family doctors and psychiatrists need the assistance of more home visitors able to assist in the rehabilitation of the convalescent mental patients.

6. Conclusion

(i) The geographic peculiarities of British Columbia have concentrated the population in the lower mainland so that most of the Province's psychiatric services are in the Vancouver area; it is more difficult to provide adequate service in the rest of the Province.

(ii) B.C.'s Director of Mental Health Services has Deputy Minister status. This appears to give him some advantage over his counterparts in the

other provinces where, with one exception, the Directors of Psychiatric Services are responsible to the Deputy Minister of Health.

(iii) The Government of British Columbia has separate institutions for the treatment of aged psychotics; as far as possible, acute psychotics under the age of 70 are treated in the Crease Clinic—patients requiring more than four months' treatment are admitted to the Mental Hospital at Essondale. This practice of separating treatment facilities on the basis of age and diagnosis should be evaluated.

(iv) The Province is developing mental health centers, which combine out-patient, day-patient, and (to some extent) in-patient treatment.

(v) Psychiatric services in general hospitals are less well-developed in British Columbia than in many other provinces—an indication of the separation of psychiatric services from other medical care.

(vi) British Columbia has more narcotic problems than any other province and is doing something about it.

(vii) Under British Columbia legislation, magistrates and judges participate in the involuntary admission of patients to mental hospital.

REFERENCES

(1) Survey of Mental Health Needs and Resources of British Columbia by the American Psychiatric Association, 1961.
(2) Department of Health Services and Hospital Insurance, British Columbia, 1962, Annual Report Mental Health Services.
(3) *Mental Hospitals Act,* Chapter 241, 1960, British Columbia.
(4) *Schools for Mental Defectives Act,* Chapter 347, 1960, British Columbia.
(5) *The Association for Retarded Children of British Columbia,* brief submitted to the Royal Commission on Health Services, February 16, 1962.
(6) *Provincial Mental Health Centers Act,* Chapter 310, 1960, British Columbia.
(7) Richman, A., M.D., and Tyhurst, J.S., M.D., *Psychiatric Care in a General Hospital,* presented at the 90th Annual Meeting, American Public Health Association, (Mental Health Section), October 15-19, 1962.
(8) *College of General Practice of Canada,* brief submitted to the Royal Commission on Health Services, May 1962.
(9) *Canadian Medical Association, British Columbia Division,* brief submitted to the Royal Commission on Health Services, February 1962.
(10) *British Columbia Division, Canadian Mental Health Association,* brief on "Psychiatric Services", submitted to the Royal Commission on Health Services, February 1962.
(11) *The Greater Victoria Metropolitan Board of Health, Victoria, British Columbia: Provision of Health Services to the Chronically Ill and the Aged,* brief submitted to the Royal Commission on Health Services, February 1962.
(12) *The Narcotic Addiction Foundation of British Columbia,* brief on Canada's Narcotic Addiction Problem, submitted to the Royal Commission on Health Services, January 1962.
(13) *Clinics of Psychological Medicine Act,* Chapter 58, 1960, British Columbia.

CHAPTER 12

CURRENT TRENDS IN BRITAIN— HOW USEFUL IN CANADA?

During the past fifteen years great changes have taken place in psychiatry in Britain. What can be learned from a study of British psychiatry that could be usefully applied in Canada? Here I shall list some of the changes and discuss how useful similar changes would be in Canada.

What I saw in the United Kingdom, convinced me that Canadian psychiatrists employed in mental hospitals should work part-time in general hospitals; this would narrow the gap between psychiatry and the rest of medicine—benefiting both the practising physicians and the provincially employed psychiatrists. More psychiatric units would then be needed in general hospitals; the senior governments should promote this change by providing advice and funds to assist in setting up and operating such units.

Besides cutting down the number of admissions to mental hospitals by treating more patients in the community, British psychiatrists have greatly shortened the stay of patients in hospital. Whereas thirty years ago, a third of all schizophrenics remained from one to several years in hospital, now in some British institutions (notably the Mapperley Hospital in Nottingham) almost all schizophrenic patients are discharged within two or three months (even though some of these require subsequent readmission). This has reduced the mental hospital population; it has also encouraged the Ministry to combat the segregation of the mentally ill by deliberately increasing its efforts to further reduce hospital stay. During the next ten years, the Ministry hopes to eliminate nearly 50 per cent of its present mental hospital beds. As some British critics point out, no one knows whether this is a realistic, or even desirable goal (yet it may be).

Early discharge not only reduces the number of hospital beds, but it also places a greater burden on the community. Nevertheless, if this program of treating psychotics in the community helps the patients—and is not too troublesome to the community—the British will likely achieve their goal of eliminating half of the mental hospital beds by 1975. The results so far are encouraging enough to warrant Canadians trying out similar plans. After studying the British program of transferring psychiatric care to the community, Canadian psychiatrists should find out how this plan will work in Canada by setting up pilot projects in carefully selected areas. In these pilot projects, the number of psychiatric beds available should be reduced to less than 1,800 per million instead of the present 3,200 per million; to make this possible would require much better community services, including improved follow up of discharged patients.

Even now some Canadian mental hospitals discharge most of their schizophrenic admissions within three months. Where this is happening, there should be funds to evaluate the influence of early discharge on the patient, and the influence of the patient on the family to which he returns. Unfortunately, the effect of the changes taking place in British psychiatry have not been scientifically determined; the British have not yet worked out the implications of these changes. Thus, while profiting from the progress in British psychiatry, Canadians, at the same time, would do well to profit from its shortcomings (chiefly the lack of evaluation). The Canadian Government should set aside funds for evaluating new programs; these funds could be administered by an independent body such as the Medical Research Council; the evaluation should be carried out by a qualified group, and by one that has no stake in the success of the program being evaluated.

In March 1961, the Minister of Health for Britain (anticipating the success of his plan to eliminate nearly half of the mental hospital beds) said that many of the 75,000 beds still needed for psychotics after 1975, should be in general hospitals rather than in mental hospitals. Yet up until now, only in the Manchester Hospital Region has there been a vigorous effort to replace mental hospital care by using general hospital beds.

In setting up pilot projects in Canada, use should be made both of the Manchester experience and of the Ministry's plans for the future. To prevent the overlapping of patients and services from geographically adjacent areas from invalidating the study, the trials should be made in areas with natural boundaries—like Prince Edward Island or Newfoundland; the areas should be selected having populations of from 100,000 to 500,000. The Federal Government should furnish guidance and some funds. In dealing with long-term patients, the psychiatrists operating the pilot projects of caring for patients other than in mental hospitals would have to compensate by providing specialized community support backed by good psychiatric services in a general hospital. From the start of the project, the results should be carefully evaluated.

A British plan of treating most psychotics in the community has worked successfully in Chichester and in Nottingham. In Chichester, the mental hospital staff working in the community provided the treatment; in Nottingham, the mental hospital staff combined with the local health authorities to carry out treatment. Both programs have produced useful data on treating psychotics outside of mental hospital.

The Nottingham program demonstrates what the local health authorities should do in a community program. Could the municipalities participate to the same extent in Canada? In Canada, local authorities have less prestige than their counterparts in Britain, where an opportunity to serve as an unpaid member of a local board is deemed an honour. Furthermore, unlike Britain, Canada has no Act compelling the local authority to provide care and treatment for the mentally ill (and mentally retarded) able to live in the community. For Canadian municipalities to play an active part in psychiatric treatment will require legal sanction, including a law that makes their responsibility clear—especially the need for the municipality to take the initiative. Somebody would have to enlist the interest and co-operation of the community leaders. Finally, a central administrative authority, such as a Federal or Provincial Government, will need to provide the funds.

Canadian municipalities, and Canadian volunteers, have played an active and useful part in providing general hospital services. This same pattern could

be tried out in a pilot project in establishing community mental health care. In addition to needing aid from municipal authorities, those conducting the experiment would require help from the local Medical Officer of Health, from public health nurses and from the local social welfare groups. Whereas in England, discharged patients are followed up by Mental Welfare Officers, in Canada this aftercare would likely be carried out by social workers and public health nurses. Certainly hostels similar to those in operation in Oxford could be established in Canadian cities. These could house handicapped schizophrenics and mental defectives, as well as many old people who could live in the community if they had homes to go to.

Part of the success of the Manchester psychiatric units stems from their close co-operation with Manchester's very good geriatric services. A project set up in Canada to treat psychotic patients in general hospitals, and in the community, should be established in an area with a good geriatric service, or at least in one in which a good geriatric service could be developed.

In discussing how Canadian psychiatry could benefit from studying the British experience, it would be unfair to leave the impression that British psychiatry leads Canadian psychiatry in all respects. A comparison of psychiatric services in Canada and Britain shows that in some areas Canadian psychiatry is further advanced. Local variations in the organization of psychiatric services are greater in Canada than in Great Britain. Even though this creates some difficulty, it is not necessarily a disadvantage. Some provinces now have few if any psychiatric units in general hospitals, and sometimes even these few units are poorly developed; in other provinces (for example, Ontario) psychiatric units are common and well-developed. Some provinces, like Nova Scotia, have successfully involved community leaders in the organization of local psychiatric services, but in most other provinces, the local communities do not participate in administering the mental hospital services.

There are certain aspects in which British psychiatry has a definite lead. Even making allowance for the dangers inherent in centralization, the British have profited from bold central planning. The financial structure in Britain permits local boards to administer funds obtained from the National Exchequer, and this makes possible decentralization without the need to raise money locally.

Great Britain outstrips Canada in providing out-patient psychiatric services in its general hospitals. It also has a law compelling the community to accept responsibility for patients with mental disorder not requiring hospital treatment. Thanks in part to a more buoyant labour market, and to more industrialization, the British are well ahead in the rehabilitation of psychiatric patients; moreover, there is a law compelling manufacturers to employ a certain number of handicapped people.

As mentioned above, the British have a long established tradition of local involvement in community welfare, whereas the Canadians have not. In Britain the general practitioners provide more help to the psychiatrists than do the family doctors in Canada; this is partly because the ratio of general practitioners to specialists is much higher in the United Kingdom than in Canada (70 per cent of the doctors in Britain are general practitioners, compared to only 41 per cent in Canada).

But in some respects Canadian psychiatry has advantages not found in Britain. The Dominion-Provincial Health Grants have provided large sums of money to try out new programs; the money has not always been used for this, but it has been available.

As a group, Canadian psychiatrists have better communications among themselves, and thus better co-operation, than have psychiatrists in any other country. This is because Canadian psychiatrists have a chance to meet frequently —thanks to the generosity and foresight of three or four national organizations. Some of the authorities sponsoring these meetings include (a) The National Department of Health and Welfare with the Annual Meeting of its Advisory Committee on Mental Health (mostly made up of Heads of Departments of Psychiatry and Directors of Provincial Psychiatric Services), (b) The Canadian Mental Health Association which, at least once a year, brings together a similar group as its advisory committee, (c) The Canadian Psychiatric Association, which compared to similar associations in other countries, is an unusually tightly knit group with excellent communications between its members.

Canadian medical schools have gone farther than British medical schools in standardizing psychiatric teaching, and they devote much more time and more effort to teaching psychiatry; graduate psychiatric teaching is also more highly organized in Canada.

To sum up, to profit in Canada from what we have learned from Britain, I would suggest the following:

(1) Setting up a number of pilot projects to try out some of the recently developed programs that have been so successful in Britain. Such programs include:

   (a) Comprehensive psychiatric services in general hospital (as in Manchester).

   (b) Treatment in the community (as in Chichester).

   (c) Integration of mental hospital and community services (as in Nottingham).

   (d) Programs based on co-operation with geriatric services in general hospitals (as in Dundee).

   (e) Programs using the British experience in rehabilitation (as in Bristol).

(2) The Federal Government should set aside funds to evaluate current programs in Canada that are novel and show promise, and to evaluate future programs. The money could be administered through the Medical Research Council; the evaluation should be carried out by competent scientists not personally involved in the success of the project which they are studying.

PART II

PSYCHIATRIC SERVICES IN BRITAIN

In psychiatry today, the most exciting changes are taking place in the United Kingdom. For at least fifteen years, British psychiatrists have struggled with problems that Canadian psychiatrists still have to face up to. Where should the mentally ill be treated, and who should do the treatment? To what extent can mentally sick persons be treated, like other sick people, in the community and in the community's general hospitals? In the treatment of psychiatric patients, what part will be played by social workers, by public health workers, by family doctors, and others?

The Royal Commission on Health Services (Canada) has sought answers to these and similar questions. During March and April 1962 I visited Britain to find out how the British were dealing with such problems, and to collect information for the members of the Royal Commission, on trends in psychiatric care. This section of the study will describe what I learned about the changes now taking place in psychiatric care in the United Kingdom.

CHAPTER 13

BACKGROUND TO THE MENTAL HEALTH ACT OF 1959, AND TO THE PRESENT

A look at the mental hospitals of Britain, en bloc, makes one ask how this ungainly conglomeration came about. What led to the creation of these 358 institutions with their more than 200,000 patients? Why are they now so isolated from the rest of medicine and from the community? Why do their patients verge so close to pauperism, and why are these patients more or less stigmatized in the eyes of their fellow citizens? Why (and this question has become less pertinent since the Mental Health Act of 1959) does their treatment require such a complicated legal structure? Since mental disorder, with its resulting symptoms of confusion, depression, anxiety, thought disorder or dullness, is a universal phenomenon, why does the burden of being a mental hospital patient fall on some mentally ill persons and not on others? Even though some patients, still in the community, are just as sick as those kept in hospitals, the many mentally sick patients who have not been institutionalized seem to have had an easier time.

The answers to these questions are hard to find. Two books by Dr. Kathleen Jones[1] provide the best source of information on the development of Britain's mental hospitals. As the works of Dr. Jones and other historians indicate, the present pattern of psychiatric service has been the unsatisfactory resultant of a struggle between, on the one hand, the need of the mentally sick for help, and, on the other, the adverse reaction of the community to the mentally disordered. From the latter came fear, stigma, denial, isolation, poor care and overcrowding. Any changes in the existing pattern of services have usually resulted from the devoted efforts of one or more well-informed and interested persons; William Tuke and the Earl of Shaftesbury[2] present outstanding examples of individuals who have greatly changed the form of psychiatric care.

In an effort to clarify the future, I shall describe how today's psychiatric care has been influenced by:

1. The Voluntary Hospitals
2. Poor Law Administration
3. County Asylums
4. Legislative Change

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[1]Jones, Kathleen, *Lunacy, Law and Conscience, 1744-1845*, London: Routledge and Kegan Paul, Ltd. (1955), and *Mental Health and Social Policy, 1845-1959*, London: Routledge and Kegan Paul, Ltd. (1960).

[2]*Ibid.*

1. Voluntary Hospitals

The best known general hospitals in Britain today are those which, prior to the National Health Service Act of 1946, were called voluntary hospitals. In part, these voluntary hospitals, as the names of many—St. Thomas's, St. Bartholomew's, etc.—bear witness, have descended from the medieval monasteries. One of the earliest of these hospitals, St. Mary's of Bethlehem, was founded in 1247; subsequently it restricted its patients to those who were mentally disordered, and it became the Bethlem Royal of today. When Henry VIII broke with Rome in 1533, the English hospitals became voluntary institutions operated by voluntary groups who raised funds by popular subscription and received some help from the government. These institutions have always been slow to accept mentally ill patients, although some (including some teaching hospitals) now have small psychiatric units. On the authority of the Mental Treatment Act of 1930, many of these hospitals have established outpatient psychiatric clinics, which are usually directed by psychiatrists from neighbouring mental hospitals.

Although subjected to the same attacks and scandals as the county asylums, Bethlem Royal survived as a voluntary mental hospital until the National Health Service Act of 1946. Except for the Bethlem Royal and Maudsley Hospital (the only teaching hospital that is exclusively psychiatric) plus the recent development of psychiatric units in general hospitals, the voluntary hospitals have contributed little to formal psychiatric care in England and Wales.

2. Poor Law Administration

Indirectly, the Poor Law administrators have shaped psychiatric services in Britain.[1] Since, during the first half of the sixteenth century, Henry VIII had destroyed many monasteries and abbeys, Elizabeth I had to set up a secular organization to look after the poor; this she did through the Poor Law Act of 1601. Then to care for the paupers, the Poor Law Guardians established almshouses and workhouses, which accumulated, in addition to the sick aged and other chronically ill persons, thousands of pauper lunatics. Despite the repeated efforts of many to transfer all of the mentally disordered to the county asylums, the workhouses continued to house some psychotics and mental defectives—usually under very poor circumstances. With the abolition of the Board of Poor Law Guardians in 1929, the local health authorities were made responsible for these workhouses. Many of the large county boroughs then turned these institutions (with their admixture of chronically ill, geriatric, and mentally disordered patients) into Municipal Hospitals; to the beds already accommodating this collection of long-stay patients, most local health authorities added beds which were for the acutely ill and for maternity cases. In the municipal hospitals which were created in this manner in the Manchester Hospital Region, the authorities set up highly effective psychiatric services which will be described later. Thus, quite by chance, the comprehensive hospital (complete with psychiatric services) came into being; since having been taken over by the regional hospital boards in 1948, many of these municipal hospitals have been strikingly improved.

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[1] *Ibid.*

3. County Asylums[1]

The County Asylum Act of 1808 created the county asylums, which during the last century, created so much controversy. Both those who wished to help the insane, and those who wanted to improve the jails had demanded the transfer of the insane from jails to some other place for treatment. Reformers criticized the care provided for the insane in workhouses. By 1792, a Quaker merchant named William Tuke, had established the York Retreat as a hospital for the mentally ill; he then demonstrated what good care could be given to the mentally disordered. In 1788, the mental illness of George III (which led to the Regency) focussed public interest on the problem of mental illness; this was soon followed by the French Revolution which stimulated interest in the less fortunate. Even in the midst of England's struggle with Napoleon, the spark of reform flamed sporadically.

The County Asylums Act empowered counties and county boroughs to build asylums for the treatment of the insane, and a vigorous effort was made to transfer patients from jails and workhouses to these new institutions. At first, only the so-called curable and the dangerous were eligible for asylum care with the incurable being retained in the workhouse; the cost of asylum care in 1820 was three times greater than the cost of care per patient in the workhouse—7 shillings in contrast to 2 shillings per week. Still attempting, in 1874, to rid the workhouses of the insane, the central government agreed to pay 4 shillings weekly towards the maintenance of each county asylum patient. Thus the precedent of using consolidated funds for locally administered services was established, and this was a forerunner of today's practice of administering mental hospitals through the regional hospital boards with the Exchequer providing the money. Counties and county boroughs were slow to build asylums during the first half of the nineteenth century, despite the enabling legislation of 1808. During the first twenty years, following this Act, only nine asylums were constructed, and by 1845 there were only sixteen in operation.

These institutions, the forerunners of today's large mental hospitals in the United Kingdom and in Canada, were usually designed for less than 150 patients. To protect the public (since lunatics were then considered dangerous) where possible, the asylums were located in rural areas. Unfortunately, at that time, no one considered treating the mentally ill in the voluntary hospital along with the physically sick; to some extent this may have been just as well, for in its then primitive state, the voluntary hospital would have experienced difficulty looking after large numbers of confused, depressed and anxious patients.

With the National Health Service Act of 1946, regional hospital boards took over the administration of the county mental hospitals (as the asylums were called after 1930). Some psychiatrists resisted grouping the mental with the general hospitals, fearing that the mental hospitals would suffer for funds in a competition with general hospitals; opposition also came from some general hospital administrators, who resented having mental hospitals placed on the same footing as general hospitals. Now, 14 years later, almost everyone agrees that putting mental and general hospitals under the same administration proved fortunate for both. Even though standards in mental hospitals still remain well below standards in general hospitals, having the same administration as other hospitals, and the same channels for financing, has benefited the mental hospitals. As a Canadian psychiatrist attending a British regional hospital board meeting, it was

[1] *Ibid.*

strange and exhilarating for me to find representatives from medicine, public health, business and labour all so deeply engrossed in the problems of "their" mental hospital.

4. Early Mental Health Legislation[1]

Changes in the laws which govern the care and treatment of the mentally ill have usually reflected changes in public attitude. To some extent, the final form after the change has taken place has been a resultant of the struggle between those, on the one hand, trying to protect the public, and on the other, those seeking legal protection for the patient.

The Vagrancy Act of 1744 legalized the jailing of disturbed mentally ill persons; this practice continued until the county asylums appeared in the nineteenth century. In 1774, the Act Regulating Madhouses arose out of public concern, lest grasping relatives and other evil-doers railroaded mentally well individuals into private mental institutions. This Act authorized a committee known as the Metropolitan Commissioners in Lunacy to license such institutions as private madhouses, and to make regular visits of inspection; thus arose the first group created by the central government for the purpose of controlling mental care.

The Lunatic Asylums Act of 1845 resulted from the great concern aroused by the poor standards of care for mental patients; this concern was felt not only for those in workhouses, but also for the patients in the 16 county asylums which by then were in operation. In part this Act was a reaction to one of those public scandals that have always highlighted the story of mental care. Mostly the Act was due to the efforts of Lord Ashley, later Earl of Shaftesbury, who devoted nearly 60 years of his life to improving the lot of the mentally disordered. The Act of 1845 granted power to the Lunacy Commission to inspect almost all of the premises which contained mentally ill patients and established the pattern (in a revised form, still in effect today) for the medical certification of the mentally ill.

During the next 50 years, both the asylums and the attitudes of people towards these asylums deteriorated badly. The Lunacy Act of 1890 was the reaction of a confused public against what most people believed the asylums to be—places in which to incarcerate the dangerously deranged. About 1875 a disturbed lady by the name of Mrs. Weldon had crystallized public concern by suing her physician for detaining her illegally. Lawyers reacted happily to the prospect of new legislation and, despite the protests of Lord Shaftesbury (who died in 1885), made admission to an asylum a judicial act rather than a medical procedure. The Lunacy Act of 1890 forced the counties and the county boroughs to operate public asylums and required that all patients admitted to these be legally certified; to keep a patient in the asylum required a magistrate's order. The Act also provided for a Poor Law Relieving Officer who was to apprehend and transport paupers certified as insane. Later called the Duly Authorized Officer, the Relieving Officer was the precursor of the very useful Mental Health Officer of today.

Instead of allaying anxiety, the Lunacy Act of 1890 increased the public's fear of insanity. All who had the funds for treatment elsewhere, avoided the

[1] *Ibid.*

asylums like plague; but the poor had no other place to go. This, in part, explains the traditional poverty of the mental hospital patient, (well-to-do people are seldom certified as insane), and it also explains why to avoid stigmatizing their patients, family doctors today treat many psychiatric disorders in general hospitals—under a physical diagnosis.

Until the end of the 19th century, despite sporadic efforts to separate the mental defectives from the psychotics, the asylum and the workhouse looked after both together. Then a rising clamour on behalf of the mental defectives led to the Mental Deficiency Act of 1913, which provided for the ascertainment of those mentally retarded persons requiring care or training. The Act directed the local authorities to set up mental hospitals for defectives; it also converted the Lunacy Commission into a Board of Control which retained the former body's watchdog function over admissions to asylums.

The Mental Deficiency Act of 1913 led to better housing and training for mental defectives. It also resulted in over-zealous efforts to segregate high-grade defectives, a practice which was only corrected in law by the passing of the National Health Service Act of 1946, and the Mental Health Act of 1959.

The Lunacy Act of 1890, with its emphasis on security, and its bogey about wrongful incarceration had dulled the public's interest in improving the lot of the mentally disordered; much of the ground gained under Shaftesbury's leadership had been lost. During the latter half of the 19th century psychiatry drifted still farther from medicine. Then the stigma of insanity (so-called) reached its zenith, and public ignorance about mental illness increased fear and denial even more.

During the first half of the 20th century, the tide turned again. The custodial nature of the county asylums, and their progressive deterioration, due to overcrowding and isolation, caused many people to have thoughtful concern about psychiatry. Led by the Voluntary Mental Health Association, after World War I, the public found ways of demanding decent facilities for psychiatric treatment. The resulting clamour led, in 1924, to a study of mental disorder by a Royal Commission; the report of that Commission was the forerunner of the Mental Treatment Act of 1930.

Amending the provision of the Lunacy Act of 1890, by which all patients admitted to mental hospital required certification, the Mental Treatment Act of 1930 made possible, for the first time, the voluntary and temporary admission of patients to mental hospital; it also provided for mental health clinics, and for the training of mental hospital staff.

This liberalizing of admission, and the modernization of nomenclature by replacing the words "insanity" and "asylum" with "mental illness" and "mental hospital", made psychiatric treatment more palatable to the public. Moreover, the establishment of mental health clinics in general hospitals was a major move towards the integration of psychiatric services into general hospitals. These steps were a necessary prelude to the movement in Britain today towards community psychiatric care.

The Mental Health Act of 1939 came after authorities realized that psychiatric treatment must be made as acceptable to the public as treatment for other types of illness; experience in World War II helped by making the public much more aware of the extent of psychiatric morbidity. Many professional organizations now demanded change. A report issued in June 1949 (after a Joint Study

by the Royal Medico-Psychological Association, the British Medical Association, and the Royal College of Physicians)[1] stated: "The argument for treating psychiatry in all essential respects like other branches of medicine was strong and conclusive... there is everything to be said for making the administrative structure of psychiatry exactly the same in principle and even in major detail as that of other branches of the health services".

All these strivings resulted in the Mental Health Act of 1959. The Act reflected the recommendations of the Royal Commission on the Laws Relating to Mental Illness and Mental Deficiency,[2] set up in 1954. In effect, it repealed the nefarious Lunacy Act of 1890, and the much better Mental Deficiency Act of 1913, and superseded the Mental Treatment Act of 1930. It did away with the practice of designating beds in mental or general hospitals as psychiatric beds, and made it possible for any hospital (mental or general) prepared to receive mentally disordered patients, to admit them in the same way as physically ill patients were admitted. The few patients who violently resisted admission could be admitted involuntarily, but the rights of the involuntary patients were safe-guarded by easy access to Appeal Tribunals set up in all of the Health Regions.

Besides ridding mental hospital care of many of its then undesirable features, the Act decentralized the psychiatric program and directed it more towards the community. It required the local authorities to establish services for the rehabilitation, training and employment of those in the community who were handicapped by mental disorder. The Act revised the nomenclature, reclassifying the mentally disordered as mentally ill, psychopathic, subnormal and severely subnormal. Psychopathic and subnormal patients less than twenty-one years old, could be admitted under compulsion as long as the compulsion, except under specially designated circumstances, was removed when the patient became twenty-five.

[1] *Op.cit.*

[2] Royal Commission on the Law Relating to Mental Illness and Mental Deficiency, 1954-1957, London, Her Majesty's Stationery Office (1957).

CHAPTER 14

CHANGING PATTERNS IN MENTAL HOSPITALS

In this section I shall describe four important psychiatric developments which I observed during visits to four mental hospitals in different parts of the United Kingdom.

1. The Open Door—Melrose[1]

During the latter part of the nineteenth century, and during the first 25 years of the twentieth, mental hospital superintendents became much concerned about security—locking up their institutions as if these were prisons. Obviously, much of this concern was an aftermath of the Lunacy Act of 1890, and was one of the tragic consequences of the legalistic approach to mental illness. Fortunately, after World War I, public attitudes towards the mentally ill began to improve. Encouraged by the liberal tone of the Mental Treatment Act of 1930, some British psychiatrists predicted that eventually the mentally ill would be treated in unlocked institutions.

At Warlingham Park Hospital, during the bombing raids of 1940-41, Dr. T. P. Rees noticed that when the doors were left open his patients did not wander away, and so in 1943 he devised a long-range plan to unlock all of the doors of his hospital; this took ten years but by 1953 Warlingham Park was completely open. The same objective was reached at the Dingleton Hospital, at Melrose, three years earlier. In January 1946, Dr. George M. Bell, Superintendent at the Dingleton Hospital, launched his campaign to unlock all the doors; by October 1, 1949, none remained locked, and since 1949 Dingleton Hospital has remained open. Since the ataractic drugs have often received the credit for the successful opening of mental hospitals, it must be made clear that Dingleton was open in 1949—four years before the ataractic drugs first appeared.

Before opening the doors of the mental hospital at Melrose, it was necessary to inform and instruct both the staff and the townspeople. In the beginning the nurses were most skeptical and anxious, and needed much information and support from the administration. The superintendent calmed many fears by insisting that he would accept complete responsibility for any harm to any patient resulting from the Open Door Program. Once the nurses realized how much opening the doors helped the patients, and how much working conditions improved, they became enthusiastic supporters of the Open Door.

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[1]Bell, George M., "A Mental Hospital with Open Doors", *The International Journal of Social Psychiatry*, Summer 1955 issue.

The people of Melrose also needed preparation for the opening of an institution that for so long had been securely locked; to this end the medical staff made detailed explanations at public meetings. Even so, when the first wandering patient unexpectedly appeared in a Melrose home, the superintendent had much tactful explaining to do. But his patience paid off, and now the townspeople accept the open hospital with pride rather than anxiety; the obvious absence of locks has favourably impressed all who visit the hospital.

Many psychiatrists thought that open doors would necessitate more staff, but Dr. Bell claims that he now runs his open hospital with fewer staff than before; violence, aggression and destruction vanished with the closed doors, and without having to lock and unlock, the nurses have more time to spend with the patients.

To the suggestion that unlocked doors could increase the danger of suicide, Dr. Bell pointed out that during the first ten years of open doors at Dingleton, the suicide rate in his area fell 42 per cent, whereas, during the same period, the suicide rate increased slightly in Scotland as a whole. Even though, admitting that it works in a rural district such as Melrose, some critics of the open door policy insist that the unlocked ward would be unsatisfactory in an urban area; yet, in the heart of Nottingham, the Mapperley Hospital has operated its Open Door program for many years with great success.

Some feared that, with the Open Door, mentally disordered patients would leave hospital on their own, and do harm in the community. During the ten years of its Open Door policy, five Dingleton patients have been charged in court for offences in the town; all were psychopaths—the policy of admitting aggressive psychopaths to mental hospitals is open to question, quite apart from the problems of unlocked doors for psychiatric patients; this problem will be considered later in this study.

Besides seeing a well-run Open Door program at Dingleton, I also saw a good Scottish Mental Hospital. The Hospital's 375 beds serve a population of 107,000 in the counties of Selkirk, Berwick, Peebles and Roxborough, which are in the southeast corner of Scotland. The rate of 3.7 beds per thousand is higher than the United Kingdom average (3.3), and much higher than the Ministry of Health's 1975 goal for England and Wales (1.8); having more than 300 of the 375 beds occupied by chronic patients partly explains the higher rate. Dr. Bell estimates that he needs only about 50 of his 375 beds for acute patients, and that with these 50 acute beds he could look after all in the district who became mentally sick. When asked why he did not transfer most of his long-stay patients to Homes for the Aged, Dr. Bell replied, "This is the best home for the aged in Scotland". Commenting on this, one British psychiatrist remarked, "but it is not the function of the mental hospital to be a home for the aged".

Whoever built the hospital took advantage of the attractive surroundings. The large glass doors at the entrance, and the strikingly beautiful and well-lighted picture in the hall make a favourable first impression; this impression remains as, without once encountering a closed door, the visitor walks through the attractive corridors into the ward. The wards have pleasant areas for occupational therapy, and recreational nooks with television. The only locks in evidence were on the inside of toilet doors—making possible a privacy quite unknown a few years back.

Dingleton's patients were older than those in an average Canadian mental hospital, and almost all were out of bed. I was most surprised to learn that

alcoholism causes more hospital admissions (per 100,000 population) in Scotland than in England. The patients worked at the traditional tasks that have always occupied mental patients on wards. Unlike the Glenside Hospital, which I had visited in Bristol, there was no paying work available for patient employment.

Newly admitted patients stayed for an average of three weeks. Chlorpromazine is commonly prescribed and, as in most British hospitals, electrotherapy is still used in the treatment of depressions. Ward morale seems high; the term "therapeutic milieu" is apt here as the pleasant atmosphere contributes to good treatment results.

Partly because Melrose is in a mill area with high employment, qualified nursing applicants are scarce. Dr. Bell objects to the educational standard that he must maintain in recruiting new staff (the equivalent of Grade XI in Canada); like many other British superintendents, he favours a lower educational minimum. Whether due to a shortage of applicants, to a shortage of funds, or to the Open Door, it was clear that Dingleton has a lower ward staff ratio than most Canadian mental hospitals.

Including the superintendent, Dingleton has a medical staff of four. Besides running the hospital, the four psychiatrists look after a busy out-patient department, which is located on the premises. All of the out-patients are adults since children with behavioural or emotional problems are referred to a child guidance clinic in Edinburgh. Many of the out-patient appointments are made to follow up former in-patients—more of these perhaps because of the short stay in hospital. The out-patient therapy comprises mostly support and reassurance, plus supervision of drug treatment. Dr. Bell and his staff have little to do with the general hospitals in the district, which are mostly small cottage hospitals; they have less to do with general practitioners than have many mental hospital psychiatrists in England. The Dingleton psychiatrists made almost no domiciliary visits; they carry on good general practice psychiatry but probably could improve psychiatry in the community by making more domiciliary visits.

As elsewhere in Britain, the physician superintendent shares the administrative responsibility with the Secretary to the Hospital Management Committee. Among its twelve members, the Hospital Management Committee includes four physicians, an almoner, a labour representative, three women and a local minister; as always, the Secretary is the business manager.

The Dingleton Mental Hospital demonstrates the Open Door at its best, and is a good mental hospital to boot; it has good relations with the local community. Compared to some other mental hospitals in the United Kingdom, it keeps a little apart from the community's general hospitals, and from its general practitioners, but all in all, Dingleton is a credit to those responsible for its present state.

2. Industrial Therapy—Bristol[1]

One of Britain's best known industrial therapy programs is at the Glenside Hospital in Bristol. In March 1962, Glenside had more than 500 persons (either former patients or patients still on the hospital books) working regularly for pay; more than 400 of these patients were employed within the hospital. They were supervised jointly by psychiatric nurses (who looked after the patients

[1] Early, Donal F., "The Industrial Therapy Organization (Bristol), A Development of Work in Hospital", *The Lancet*, October 1, 1960, pp. 754-757.

themselves) and by the factory foremen (who supervised the patients' work on behalf of the participating company). The several Bristol manufacturers who took part had joined the program because their firms made the sort of product that needed the work of many hands, and that could be manufactured in a mental hospital. Plant managers assigned skilled foremen to organize and supervise production, and the hospital provided the labour. To cite an example, some patients stapled cardboard boxes, and made Christmas trinkets. They worked five hours a day, 25 hours each week, and earned up to a maximum of two pounds a week (if earnings had exceeded two pounds a week, then an insurance contribution would have been necessary). Excess earnings were pooled to help re-establish patients who had previously left hospital. The total earnings of patients employed in the hospital exceeded £15,000 in one year.

A non-profit company in Bristol, called the Industrial Therapy Organization (ITO), employs almost 100 patients outside hospital. Organized by a group of volunteers, ITO runs its own factory in a former schoolhouse, and also operates a nearby car wash. For the most part, the patients working in ITO came from the chronic mental hospital wards; they were considered hopelessly chronic until they had joined the industrial therapy program on the hospital wards. Although some of these patients still sleep at the hospital, all work a 40-hour week outside. Accepting the responsibility granted local health authorities by the Mental Health Act of 1959, the Bristol Council plans to establish hostels to house those in the program that have no homes to go to.

The industrial therapy program began in 1958, when the hospital employed 14 patients to work on a small contract from a pen company. Through the program the hospital has discharged 136 patients from its chronic wards; these patients are now on their own—mostly in full-time employment. Much credit for the success of this venture belongs to Dr. Donal Early, a consultant psychiatrist with a staff appointment at Glenside. His experience has convinced Dr. Early that, in the treatment of chronic patients, industrial therapy is more useful than pills. He believes that half of the long-stay patients now in mental hospitals could be gainfully employed, resulting in the discharge of many who otherwise would remain in hospital for the rest of their days. Only the very old, who are physically ill as well, are quite unable to do the work; among those who start on the program, most of the failures occur among the schizophrenics and the psychopaths. In Glenside, industrial therapy has replaced traditional occupational therapy, raising the question as to whether registered occupational therapists should devote more time to industrial therapy.

Critics of industrial therapy programs complain about the amount of technically skilled supervision, which they wrongly consider these programs need in hospital; they also complain of the psychiatric supervision needed when the patient moves into the community. They also mention the need for agreement with labour unions—lest a charge of unfair labour practices result (the unions have solidly backed the scheme at Glenside). Some fear that too much zeal by the staff for industrial therapy may eliminate other useful therapeutic programs.

A few other British mental hospitals have developed industrial therapy on a large scale—and many others on a much smaller scale; although precise evaluation of the results has not been done, it appears that the programs have emptied many hospital beds. Industrial therapy has legislative support in the 1959 Mental Health Act, which required local authorities to train mentally handicapped persons, and to assist both the mentally ill and the mentally retarded to find employment and shelter in the community. There is also a

helpful law, called the Disabled Persons Act, compelling employers to include a definite percentage of handicapped persons among employees hired. Unfortunately, many of the programs and resources contributing so much to the rehabilitation of the mentally disordered in Britain are not yet available in Canada.

Both the Glenside and the Barrow Hospitals at Bristol illustrate the transition taking place today in psychiatry in Britain. The Glenside Hospital is more than one hundred years old but has an air of optimism and activity, which in part comes form its industrial therapy program. Although more than twenty years old, the Barrow Hospital was one of the last mental hospitals built in Britain; a most attractive place—it too is a hive of activity. One of Barrow's staff consultants, Dr. R. E. Hemphill, has had much to do with psychiatric progress in the Bristol area. He now has an active day-care program, which he is hoping to enlarge as more transport becomes available. The optimism, enthusiasm and drive of the British consultants in psychiatry astounds a Canadian visitor. We need to ascertain the explanation of this combined eagerness and perseverance, and then to reproduce it in Canada.

3. Mental Hospital Operated Community Services—Chichester[1] [2]

The Chichester area has produced the most dramatic story on the community care of psychiatric patients; here the staff of the Graylingwell Mental Hospital operates two large programs of community care and treatment. In 1957 the first of these was established in the Worthing and District area (1957 population—160,000), and the second began in 1958 in the Chichester and District area (1957 population—110,000). The Graylingwell Hospital, which on January 1, 1959, had a patient population of 995, serves Worthing, Chichester, Horsham and Districts—all of which had a combined population in 1961 of 410,000.

Since the Worthing and District experiment in community care and treatment was established first, it will be used to illustrate what is happening in the entire program. Situated on the English Channel, about 20 miles east of the town of Chichester—where the Graylingwell Hospital is located—the town of Worthing lies in a populated area of 160,000. Except for rare emergencies (mostly at night) before any mental patient from the Worthing area can be admitted to the Graylingwell Hospital, he must be seen at Worthing by a member of the Graylingwell Hospital staff. If admission proves necessary, the patient is then taken to Graylingwell; more than 70 per cent of those referred do not require admission and remain in the Worthing area where they are treated in the community by the staff of the psychiatric service.

The program is operated by 12 staff members working in (or from) a building in the town of Worthing called The Acre. The staff includes 2 full-time and 2 part-time psychiatrists, 2 doubly trained nurses (both in general and psychiatric nursing), 2 orderlies, 2 social workers, 1 occupational therapist and a secretary. Most patients are referred by the family physicians of the district, and are seen at the day center in The Acre, or at an out-patient clinic in the Worthing General Hospital, or in the patient's own home. In 1958, 411 patients were seen in the Worthing Hospital Clinic, 288 in the day center, and 564 in their own homes. Two hundred and forty-seven of the 1,253 patients examined

[1] Carse, Joshua, "A District Mental Health Service", *The Lancet*, January 4, 1958, pp. 39-41.

[2] Carse, Joshua, "Community Care and Treatment of the Psychiatric Patient", *The Practitioner*, November 1961, Vol. 187, pp. 672-678.

in 1958 were admitted to the Graylingwell Mental Hospital. This compared with 645 admitted to Graylingwell from the same population in 1956—the year before Dr. Joshua Carse set up the program at Worthing. The day center in The Acre provides almost every type of modern psychiatric treatment including psychotherapy, electrotherapy, and modified insulin—but not coma insulin.

The story began in Graylingwell in 1954 when Dr. Carse realized that the spiralling admission rate would soon result in a badly overcrowded hospital; in an effort to lower the admission rate and hold the hospital population constant, he decided to treat some of the patients in the community rather than in hospital. His inspiration for this project came in part from the experience of Querido who had operated an emergency psychiatric service for 25 years in the City of Amsterdam. Querido's peripatetic psychiatrists treated many mentally disordered patients in their own homes and so prevented a large number of hospital admissions. While still planning the Worthing program, Dr. Carse and members of the Hospital Management Committee visited Querido at Amsterdam.

The Nuffield Trust Foundation agreed to finance the first two years of the Worthing experiment. The project produced a 60 per cent decline in the annual admissions from the Worthing area to Graylingwell, and also contributed to a 10 per cent reduction in the total number of patients in hospital. Domiciliary visiting for assessment or for treatment was another factor in keeping hospital admissions low. Psychiatrists and social workers made the initial call, followed by psychiatric nurses; (the National Health Service pays psychiatrists 4 guineas for the first domiciliary visit to any patient).

To operate, the Worthing project cost about £20,000 annually, at an average of about 7 shillings per patient per week; this compared favourably with the one pound daily cost of treating patients in Graylingwell. The project dealt with more than 1,000 patients a year.

Encouraged by the success of the Worthing project, the Regional Board established a similar program in Chichester and District, with comparable results. The Worthing and Chichester projects stimulated much discussion, and others have tried similar programs. Although not the only effort in Britain to treat psychiatric patients in the community, this was certainly the most dramatic and the best publicized.

Many obervers have asked to what extent this sort of community treatment might replace mental hospital care. Opinions on this are changing; in January 1958 (soon after the program began) Carse said: "It should not be thought, however, that our experience has led us to the conclusion that the mental hospital is an anachronism and redundant; indeed our respect for it has increased". Yet in 1962, after 4 years experience with the Worthing scheme, he said: "The process of winding up our mental hospitals has already begun...", "and... in 30 years' time there will be very few patients in any mental hospital—or indeed, any in mental hospitals as we know them today". It is still much too soon to tell whether this and related programs at Nottingham, Manchester and other places are really sounding the knell of Britain's mental hospitals—but they may be.

Have the families of the 400 patients kept out of Graylingwell suffered as a result of these patients being at home instead of in hospital? To answer this

question, Dr. Peter Sainsbury and Dr. Jacqueline Grad have set up an extensive research program based on Graylingwell. They are comparing the situation of families in the Chichester area (where many patients have been treated in the community) with that of families 60 miles away in the Salisbury area—who have members being treated in mental hospital. So far they have shown that, although the presence of a sick and disturbed patient may upset a family, no serious harm results as long as patients are hospitalized once they become very disturbed, and provided that the family of the patients selected for community treatment receive adequate support from competent professionals.

It seems that domiciliary visiting involves the psychiatrist at an earlier stage in the patient's illness, and so keeps the family from rejecting the patient completely; as a result families are willing to keep patients home for longer periods. Some critics of the Worthing program question the wisdom of having the Graylingwell doctors, social workers and nurses do most of the work themselves; they suggest that the general practitioners and the local authority social workers should officially play a larger part in treatment since they are in the community and already practise a good deal of unofficial psychiatry. Although the Worthing project preserves the general practitioner's contact with his patient, why could not the family doctor himself (with specialist help) do more of the treatment. Despite their reputation for slavish adherence to tradition, the British are essentially a practical people, and so are prepared to experiment with a variety of professionals treating patients under the supervision of a psychiatrist; as a result there is an increasing tendency to use the psychiatrist as a consulting specialist rather than as the exclusive therapist.

In comparison with mental hospitals anywhere, Graylingwell is a good hospital, and has been so for many years; the high admission rate that originally started the train of events leading to the Worthing scheme resulted from its good reputation. Aside from reducing admissions and patient population, the community programs in Worthing and Chichester have not changed the hospital much. It has been suggested, but not established, that the publicity and glamour of the community program may have overshadowed the work of the hospital itself, and so damaged the morale of those who work only in it. The operating costs at Graylingwell approximate the national average, with the 1958 budget amounting to £400,190, making a weekly cost per patient of more than £7.

The hospital now serves a population of 410,000. Its Hospital Management Committee is responsible to the Regional Hospital Board of the southwest metropolitan region which, in turn, serves a total population of 3,160,000. Because this region includes part of London, it has an abnormally large number of mental hospital beds—and several institutions; these hospitals also serve some London areas that are under other Regional Hospital Boards. The southwest metropolitan region now has 22,921 mental hospital beds, making a ratio to population of 7.2 per thousand (more than twice the national average). This high rate is a temporary artifact which results from regional boundaries crossing municipal boundaries, and will soon be corrected; future plans call for a reduction of psychiatric beds in this region to 9,100 by 1975, with Graylingwell reduced to 750 beds.

4. Jointly Operated Community Services—Nottingham[1] [2]

Thanks to an arrangement that the Superintendent of the mental hospital in Nottingham has worked out with the Local Authority, this city has unusually good psychiatric services. Dr. Duncan Macmillan is both Superintendent of the Mapperley Mental Hospital and Medical Director of Mental Health in Nottingham; he is the mental health consultant to the Medical Officer of Health—to whom he is responsible for community mental health services. In response to requests from general practitioners, psychiatrists and social workers make domiciliary visits to the homes of patients with, in most cases, the social worker making the first call. In deciding what to do with the patients, the options available to the psychiatrist include:

(a) referral back to the family doctor with advice as to care,
(b) domiciliary visits later by the social worker,
(c) referral to a day center, and
(d) admission to the mental hospital.

Nottingham has five day centers including one for old people, which is operated by the Local Authority, and financed by a grant from the Nuffield Hospital Trust Foundation; there are also three day care units attached to branches of the Mapperley (Mental) Hospital.

During 1959, 598 (58 per cent) of the 1,043 patients referred to mental health services were admitted to Mapperley, compared to a 73 per cent admission rate on referrals three years previously; this reflects the trend in English psychiatry towards restricting unnecessary mental hospital admissions. Many hospitals now try to limit admission to those patients who need treatment that is only available in hospital, or to patients whose behaviour is dangerous or disturbing to the family or to the community. This screening of admissions contrasts with practices of a decade ago when, on their own authority, general practitioners, on a relative's petition and on a magistrate's order, could certify a patient and direct a duly authorized officer to take him to mental hospital. Then the hospital authorities could not refuse to accept the patient, but under the 1959 Act refusal is now possible if no bed is available.

The Nottingham story makes clearer the picture of psychiatric services in Britain. In 1930, like all mental hospitals, Mapperley was operated by the Local Authority. When the Mental Treatment Act of 1930 authorized mental health clinics in general hospitals, psychiatrists from Mapperley Hospital opened a clinic at a Nottingham general hospital. First, as Director of the mental health clinic, and later as Superintendent of the Mapperley Hospital, Dr. Macmillan worked out a community psychiatric service that drew together the clinics, the field staff of the Local Health Authority, and the mental hospital.

When the National Health Service Act became effective in 1948, the Mapperley Hospital (like all British mental hospitals) was placed under the Regional Hospital Board, and thus divorced from its former community mental health responsibilities—which the Act had now assigned to the Local Health

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[1] Macmillan, Duncan, "Community Treatment of Mental Illness", *The Lancet*, July 26, 1958, pp. 201-204.

[2] Macmillan, Duncan, "Community Mental Health—The Mapperley Hospital Scheme", *Canada's Mental Health*, Special Supplement (1960).

Authority. But a Section of the Act permitted regional boards, and Local Health Authorities to administer mental health clinics jointly; so Dr. Macmillian used this authority to preserve and expand the service he had previously created. He negotiated an agreement between the Regional Hospital Board, and the Local Health Authority, which brought together, under his direction, the four mental hospital social workers, and the seven Duly Authorized Officers (now called Mental Welfare Officers) of the Local Authority. With this total of 11 community workers at their disposal, the mental hospital psychiatrists now operate both the out-patient clinics and all of the Local Health Authority psychiatric services.

Thus the community psychiatric service nominally came under the Medical Officer of Health whose chief consultant was the Superintendent of the mental hospital, who, in turn, was assisted by other consultants from the hospital and by the 11 social workers. On behalf of the Medical Officer of Health, the members of this group operated:

(a) domiciliary consulting service,
(b) a day-center for aged,
(c) a children's psychiatric clinic for the local educational authority, and
(d) mental health clinics at the general and mental hospitals.

Under the direction of the psychiatrist, the 11 social workers visited new referrals, attended hospital conferences when these patients were admitted to hospital, and followed up the patients after discharge.

Overcoming their initial aversion to having their patients scrutinized by psychiatrists before admission, the general practitioners began to work more closely with psychiatrists and social workers, especially on domiciliary visits. To make communications better, some of the psychiatrists meet weekly with family doctors to discuss patients.

Mapperley Hospital has 895 patients, which is 100 fewer than authorized accommodation. This is a decline of 400 patients during the past 10 years, and reflects the success of the community treatment program—including more careful choice of admissions. Mapperley is divided into four different units with 570 patients in the main building, 64 patients in a separate acute treatment unit, 190 patients in a psycho-geriatric service located in what was at one time part of the local workhouse, and finally two hostels with a total of 60 beds.

Ninety per cent of the patients are admitted informally to Mapperley without admission documentation of any sort. Like Dingleton, Mapperley is an open hospital, for like Dr. Bell, Dr. Macmillan also pioneered the Open Door. He has stressed the therapeutic community, and has abolished the rigid segregation of men and women which, in the past, has plagued psychiatric treatment in hospital.

The decline in in-patient population results from no longer adding patients to the long-stay group. Of the 660 patients admitted in 1954, only 9 remained in hospital when this group was reviewed in 1957, and among these 9, there was not a single schizophrenic; 5 of the 9 patients were over the age of 65. To make sure that the long-stay group becomes smaller, not only are no new members added, but when a resident of the long-stay ward dies, or is discharged, the empty bed is removed from the chronic ward.

Instead of admitting patients to the chronic wards, the staff treat many of these in the five day centers. Emptying wards thus had made space available for

extending the day service, which in turn helps empty more wards. As elsewhere in Britain, the hospital and the Local Authority operate a bus service for transporting day patients.

As provided in the National Health Services Act of 1947, the hospital administrators include the physician superintendent and the secretary, both of whom report to the Hospital Management Committee. The Regional Hospital Board appoints the chairman of this Hospital Management Committee, which includes three members selected by the Committee itself, three selected by local physicians, three by the executive council (the committee which administers general practice and other services), three by the Local Authority and three by local businessmen. As elsewhere, the Hospital Management Committee is responsible, through its chairman, to the Regional Hospital Board. Nottingham is in the Sheffield region, whose Board serves 4,270,000 persons—making it one of the largest hospital regions in the country.

An outstanding success, the Nottingham Community Mental Health Service has provided that city with high-class psychiatric care. Its achievements in domiciliary care, in combining mental hospital and community services, and in better selection of hospital admissions, has encouraged other areas to try similar methods. Yet, as many critics have pointed out, this program can be credited mostly to one man—Dr. Duncan Macmillan. Without such skilled leadership, could the results be reproduced elsewhere? Critics pose other questions; would it not be better to have a closer liaison with the general hospitals, and would not such liaison cause other doctors to become more interested in improving their psychiatric skill? Although Dr. Macmillan expects psychiatry to become more a part of general medicine, I was surprised to hear a prominent member of his Management Committee express amazed incredulity at a suggestion that psychiatric patients might be treated in general hospitals. One final query: would it not be advantageous for general practitioners (working with the social workers) to bear more responsibility for psychiatric treatment in the patient's home?

I must conclude by saying that this is a very good mental hospital, and that if all mental hospitals could become as good there would be less concern about the separation of psychiatry from the rest of medical care; unfortunately, few mental hospitals are likely to reach this standard.

CHAPTER 15

CHANGING PATTERNS IN GENERAL HOSPITAL PSYCHIATRIC SERVICES

1. Psychiatric Services in General Hospital

In England and Wales, the prevailing trends indicate that soon more psychiatric services will be established in general hospitals. To date, despite the support that this type of care has received from many quarters (including the Ministry of Health), the number of psychiatric beds in British general hospitals is surprisingly small. Aside from the 1,639 beds in the 15 psychiatric units in the Manchester Hospital Region, there are only 3,003 psychiatric beds[1] (in 68 units) in the remaining 2,600 hospitals (total beds, about 265,000); these hospitals, it is true, include many that are either too small to warrant a psychiatric unit, or are chiefly restricted to one medical specialty. Considering the efforts of many to integrate psychiatry with the rest of medicine, and the success of psychiatric clinics in general hospitals, the development of in-patient psychiatric services in British general hospitals has certainly lagged. In one of the country's 15 hospital regions, there are no psychiatric units in any general hospital; two other hospital regions have only one psychiatric unit in each.

Almost all Regional Hospital Boards have drawn up plans to add psychiatric units to their general hospitals during the next 15 years. For the most part, these units are for short-term and medium-stay patients, and in most cases, Regional Boards will continue to depend on local mental hospitals to absorb the long-stay patients. The North West Metropolitan Hospital Region (including part of London) presents a slightly exaggerated illustration of the changes taking place; it now has about 2.6 beds per 1,000 compared with the national average of 3.4 beds per 1,000. The Regional Hospital Board in this area plans to add psychiatric units totalling more than 1,100 beds, and at the same time, to reduce the total mental hospital population by 4,500 beds. The North West Metropolitan Region will then have 4.5 psychiatric beds per 1,000 in general hospitals, and these will make up one-quarter of all the psychiatric beds in the region.

The administrative problems of psychiatric units in general hospitals have attracted much attention in Britain. Many point out the difficulties that arise when a psychiatric unit is created without proper regard to its particular needs. Hospital administrators have learned that the somewhat authoritarian regime suitable for a surgical ward will not do in psychiatry. Both those who favour psychiatric services in general hospitals, and those generally opposed to such

[1] *A Hospital Plan for England and Wales*, London: Her Majesty's Stationery Office, January 1962.

services, agree that psychiatric units will not work out unless the general hospital supplies adequate accommodation for day care and for occupational and recreational therapy, and unless it strives to create a proper therapeutic milieu. Where the units work well, the hospitals have been willing and able to do this. Could all general hospitals do as well if psychiatric units became universal? One would hope so, but only experience can provide the final answer.

In place of (sometimes in addition to) establishing psychiatric units for patients in general hospitals, some hospitals now admit selected psychiatric patients to their regular medical wards; Brook and Stafford-Clark[1] report an interesting example of this in the Newcross General Hospital. The extent to which known psychiatric patients can be admitted to the medical wards will depend on the accessibility of consultant psychiatrists, and to the tolerance of ward nurses—many quite unaccustomed to psychiatric nursing. Even so, it is estimated that from 10 to 20 per cent of the general medical beds are now occupied by patients whose chief disability is psychiatric. Even in hospitals with an active psychiatric service, not more than 5 to 10 per cent of those mentally disordered patients are referred for psychiatric investigation; the same high ratio of psychiatric pathology exists in medical and surgical out-patient departments. This relatively low rate of referral results not only from the scarcity of psychiatrists, but also from the success of some general physicians in handling minor psychiatric disorders.

One question in Britain concerns the extent to which psychiatric units in general hospitals can eventually replace mental hospitals; this is part of the great debate going on concerning the future structure of psychiatric services. Whether psychiatric units in general hospitals (or the type of psychiatric services in the comprehensive hospital planned by McKeown in Birmingham) can replace the mental hospital, will not be determined for a few years yet. The decision can only come after assembling more facts on the experience of psychiatric units now being operated in general hospitals (including those in the Manchester area).

Any hope of developing services in general hospitals that could replace all mental hospitals depends on establishing close liaison between the psychiatric units and the community; psychiatrists would need help from the general practitioners, from the local health authorities, and from the voluntary mental health organizations. At the same time, the staff of the psychiatric units in general hospitals would need the support of geriatricians and hospital administrators. More long-stay annexes for geriatric patients would be needed, and also more hostels for the homeless mentally handicapped.

The British still lack the funds needed to make a thorough attempt to establish psychiatric care as part of general hospital service, but they do not lack the will.

2. Comprehensive Psychiatric Services in General Hospital Units in the Manchester Region[2]

Although the Manchester Hospital Region contains less than 10 per cent of the population of England and Wales, it has 20 per cent of the nation's psychiatric units in general hospitals (15 of 181); these 15 psychiatric units have more than 35 per cent of all the psychiatric beds in general hospitals in the country.

[1] Brook, C.P.B., and Stafford-Clark, David, *The Lancet*, May 27, 1961, pp. 1159-1162.

[2] Freeman, H. L., "Oldham and District Psychiatric Service", *The Lancet*, January 23, 1960, pp. 218-221.

Only 4,642 (about 3 per cent) of England's 139,483 beds for the mentally ill are now located in general hospitals, but 1,635 (16 per cent) of the Manchester Hospital Region's 11,820 beds for the mentally ill are in general hospitals; thus the Manchester Region is far ahead of the rest of England and Wales in placing its psychiatric services in general hospitals.

How these psychiatric units began, how they operate, and what is planned for them is one of the most important stories in present day psychiatry.[1] After surveying all the psychiatric units in general hospitals in the Manchester Region, Dr. Stanley Smith (now Superintendent of the Lancaster Moor Mental Hospital, and a former Professor of Psychiatry at the University of Alberta)[2] said: "In my view, it may well be the most significant social development in British psychiatry today".

The Manchester Hospital Region has a population of 4,395,000 residents, of whom two-thirds live in the City of Manchester, or in the large urban areas which surround it. Most of the 15 psychiatric units are located in general hospitals (formerly municipal hospitals or wards in workhouses) of these large urban towns, and in the northern and northeastern parts of the County of Lancashire (except for two units in the County of Cheshire). Twelve of the 15 psychiatric units are located in general hospitals that also have acute beds; three are in hospitals with only geriatric and psychiatric beds.

The units vary in size from 36 to 250 beds, with a mean of 115; each serves a catchment area with an average population of about 200,000. Each year, each unit admits an average of 200 patients (with such active units as at Burnley, Rochdale and Blackburn admitting as many as 600 patients a year), and transfers, on the average, six patients to one of the Manchester Region's five large mental hospitals. Several of these units, however, admit all of the mentally ill patients needing hospital care in their 200,000 person catchment area, and transfer none to large mental hospitals (a few patients go directly from areas served by these units to the large mental hospitals, but usually only for personal or social reasons—almost never because of difficulty in management). From some of the units, an occasional patient will be admitted to mental hospital when a psychiatric unit is temporarily hard-pressed for beds.

For the most part, these 100-200 bed psychiatric units in population areas of from 200,000 to 250,000 provide all the psychiatric hospital service needed—acute or chronic. They accomplish this with a ratio of about .7 (.5-.8) beds per thousand population, compared to the national ratio of 3.3 beds per thousand. When one contrasts the .7 figure with the Minister's 1975 goal of reducing the mental hospital beds to 1.8 per thousand, the Manchester figures are striking indeed.

To make this accomplishment even more remarkable, the Manchester statistics reveal that 50 per cent of the 1,635 psychiatric beds contain chronic patients, most of whom were already in the units when these were formally taken over by the Regional Hospital Board in 1948; these chronic patients—many of whom will stay until they die—include a number of long-stay schizophrenics, mental defectives, and patients with chronic neurological diseases.

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[1] Maclay, W. S., *Journal of Canadian Medical Association*, 78: 12, 1958.

[2] Smith, Stanley, "Psychiatry in General Hospitals—Manchester's Integrated Scheme", *The Lancet*, May 27, 1961, pp. 1158-1159.

The program began after the National Health Service Act became effective in 1948. At that time, the Manchester Hospital Region was served by five large mental hospitals —with a total patient population of more than 10,000; almost all of the psychiatrists in the region were on the staff of one or other of these hospitals. If it had followed the same pattern as did the other 14 regions in England and Wales, the Manchester Regional Hospital Board would have divided the service responsibilities for the Manchester area between these five large mental hospitals, with each mental hospital admitting those needing in-patient treatment, and at the same time running mental health clinics in nearby general hospitals, and because the mental hospitals were poor and overcrowded, the Mental Health Committees of the Regional Hospital Board shrank from planning a mental health program around these institutions;[1] instead the Committee recommended that an effort be made to establish psychiatric services within the general hospitals. Thus, part-time consultant psychiatrists (each already with appointments on one of the five mental hospitals) were attached to several general hospitals, and asked to treat as many psychiatric patients as possible in the general hospital.

Since the general hospitals selected were former municipal hospitals, most already had a number of designated psychiatric beds; these designated psychiatric beds were relics of the old workhouse, and contained the remnant of the "pauper insane". Even before the National Health Service Act of 1946, acute and maternity beds had been added to many of these municipal hospitals, and in reality they had become general hospitals; architecturally and in most other ways, they were quite inferior to the voluntary hospitals in which most of the beds for treating acute physical illness were located. Dr. J.S.B. Mackay, Deputy Senior Administrative Officer of the Manchester Hospital Region, told me that, in 1950, he had hoped that attaching psychiatric consultants to the general hospitals would lead to better integration of psychiatry with other medical services; his hopes were realized beyond all expectations.

In the beginning, in Manchester and elsewhere, this effort to set up psychiatric services in the general hospitals was greeted with skepticism. The psychiatric consultants seconded to the "Council" hospitals were the first to become excited over the possibilities of the plan; as their programs developed, and the success of psychiatric service in the general hospitals became assured, most of these consultants discontinued their formal contacts with the parent mental hospital.

Although the program has been established in 15 hospitals, the best known units are at Oldham,[2] Bolton, and Blackburn, all of which have been reported in the literature in detail. The psychiatric services in each of the 15 hospitals have, for the most part, developed similarly, although at different speeds.

As time went on, each consultant acquired one or more full-time medical assistants. The classification of these extra psychiatrists ranged from senior house officers to senior hospital medical officers; part-time general practitioners were hired to help some of the consultants in the wards, and in the out-patient

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[1] Marshall, F. N., Smith, Stanley, *Regional Psychiatric Services*, Manchester Regional Hospital Board (March 1961).

[2] Keddie, J. T., Chalmers, *Psychiatric Services: The Oldham Scheme*, The Royal Society of Health (April 1960).

departments. These general practitioners work a specified number of sessions, and carry out both psychiatric and physical treatments.

In the course of setting up their psychiatric services, most of the consultants developed close and cordial relationships with the local health authority staff, from whom they received a good deal of assistance—especially from the mental welfare officers. In Blackburn, Dr. Maurice Silverman, the consultant psychiatrist, had the seven mental welfare officers helping him as social workers in the community; his contact with the local health authority staff was well maintained, thanks to frequent conferences on patients at the psychiatric unit.

In this program at the Manchester Hospital Region, the consultant psychiatrist had to iron out many problems; some of the most difficult arose because the wards were filled with long-stay patients, which each consultant fell heir to. Although he needed to clear beds so he could admit acutely sick patients, each consultant had trouble disposing of the long-stay neurological cases, schizophrenics and mental defectives. Handicapped by so many chronic patients, in the beginning, the staff at first transferred some patients to mental hospital, but, as the units became better organized, the number of these transfers diminished. Of 331 admissions to the psychiatric unit at Oldham during 1956, none were transferred to mental hospital, and of 111 admissions to the unit at Rochdale in the same year, only two were transferred. Eventually little contact remained between the psychiatric units and the big mental hospitals.

Treatment in the psychiatric units is carried out by a resident medical staff of from one to four physicians under the supervision of a consultant. All of the common physical psychiatric treatments were available, plus some individual and group psychotherapy. Since there is no more than one psychiatrist for each 50 ward patients, success in treatment depends to a great extent on the therapeutic milieu created by the nursing staff; the nurses also take an active part in recreational and occupational therapy. Volunteers operate social clubs for both in-patients and out-patients.

Since most of the 15 psychiatric units are in general hospitals containing large and active geriatric services, many aged confused people from the area are admitted to the geriatric wards rather than to psychiatry; in most units the psychiatrist takes only the depressed and the disturbed old persons; an exception to this is the female psycho-geriatric service in the psychiatric unit at Oldham. In estimates of future bed needs, the psychiatric consultant at Oldham has planned for many more old people, and wants a bed complement as high as 1 to 1.5 per thousand—compared to the .5 to .8 beds per thousand requested by the heads of other units in the Manchester Region. Except at Oldham, the prevailing trend is to admit confused old people to geriatric services, thus making fewer psychiatric beds necessary.

In each unit, the day care program plays an important part in keeping the need for beds within definite limits. In line with its policy of admitting a relatively greater number of old people, the Oldham unit has a comparatively larger geriatric day care service. At Oldham, as elsewhere, transportation is provided for most day care patients.

Each unit operates an active out-patient department; some of these out-patient services look after as many as 500 new patients each year, with total visits exceeding 5,000. Most of the out-patients are referred by general practitioners with the number of referrals depending on how closely the family

doctors work with the psychiatrists; thus the number of referrals varies a good deal from one area to the next. Where the communications with the general practitioners are especially good, more domiciliary visits occur.

What is the future for these psychiatric units, and to what extent will the pattern seen in the Manchester Hospital Region be reproduced elsewhere?

Since the buildings housing the units are poor, plans are going ahead to modernize and upgrade the accommodation. The Regional Hospital Board plans to add more beds wherever the pressure for admission is very great. Given bed ratios between .5 and 1 per thousand population, most unit directors believe that they can provide a complete service to the area in which they are located—looking after all psychiatric patients needing hospitalization. To make this work, they would all need help from the local authority social workers, close co-operation with the general physicians, a good day care program, and in some instances, one or two more psychiatrists than they now have. Most directors want more female beds than male—a ratio of three to two.

There is an atmosphere of dedication and optimism among the psychiatrists in the psychiatric units in the Manchester Hospital Region. This good morale reflects good leadership, and (so many believe) a good plan. At present, the Board is considering an increase in the number of units from 15 to a total of 18 or even more.

The Manchester development supports those who believe the large mental hospitals are obsolete; yet not all agree with those who think that this type of service renders mental hospitals unnecessary. One of the unit psychiatrists, Dr. J. T. Leyberg[1] of Bolton, has said: "A psychiatric unit in a general hospital can never offer the best conditions of rehabilitation to chronic patients, particularly the female schizophrenic.... As the number of chronic patients gradually increases, a small unit may soon become unable to admit new cases". Others have criticized the program, suggesting that it is returning large numbers of insufficiently treated mentally ill patients to the community, and that these patients place a heavy burden on their families and on society. It is evident that a careful evaluation of this most interesting program is needed before its implications can be fully understood. The big questions are: "Would this type of psychiatric organization speed integration of psychiatry into medicine? Would this be best for the patient and for the community?" These questions will be considered later in this study.

With some justification, critics claim that mentally disordered persons with criminal tendencies create insurmountable problems in this type of unit; although this is true, it must be noted that patients with criminal tendencies usually do just as badly in mental hospitals.

To sum up: whatever shortcomings become apparent from evaluation of the Manchester experiment with psychiatric units, it must be stated that the plan has succeeded far beyond expectations. Regardless of whether the present pattern prevails in future, or is ultimately superseded by something better, psychiatrists will have learned a great deal from the Manchester experience.

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[1] Leyberg, J. T., *The Lancet*, 1959, ii, p. 282.

CHAPTER 16

ORGANIZATION OF PSYCHIATRIC SERVICES

1. Central—Including National Health Services

In the three preceding sections of this study, I have described programs that illustrate what is taking place in British psychiatry today. Reference has been made to the Mental Health Act of 1959, and to its historical background. To fully understand psychiatry in Britain, it becomes necessary to understand its place in the British governing structure, and in the National Health Service.

The Minister of Health carries out his duties under Acts providing legislation for the health services of Britain. The National Health Service Act of 1946 established the present structure. It set up legislation for the National Health Service, which provides complete medical care for 45,756,000 persons in England and Wales.

The National Health Service has often been likened to a three-legged stool because, at the local level, its services are administered through three separate agencies:

(i) The Executive Councils
(ii) The Local Health Authorities
(iii) The Regional Hospital Boards.

The Executive Council is a local committee set up to hire and pay the general practitioners, dentists, and pharmacists. Based on an annual budget submission, funds for this come from the National Exchequer. For the most part the administrative responsibility of an Executive Council covers an area coterminous with a county.

The Local Health Authorities administer the health services of the 62 counties and 82 county boroughs. The responsibility of these Local Authorities for psychiatric services is described later.

Most of the Ministry's mental health responsibilities are carried out through its communications with the Regional Hospital Boards and with the Local Authorities. Before the Mental Health Act of 1959, the central authority for psychiatric services rested with the Board of Control, which was abolished by the 1959 Act. After the Board of Control was eliminated, the departmental officers of the Ministry took over the Board of Control's former responsibility for planning and inspecting psychiatric services. For the most part these officers (under the Chief Medical Officer of the Ministry) established policies which are

administered locally under the supervision of the mental health committees of the Regional Hospital Boards, and of the Local Health Authorities.

The National Health Service Act of 1946 divided England and Wales into 15 hospital regions—each serving between 1,500,000 and 4,500,000 people. Since these regions cut across the boundaries of counties and of metropolitan districts, mental hospitals in one region may contain patients from another. Because of their special needs, the teaching hospitals in England (although not in Scotland) were placed under special Boards of Governors rather than under the Regional Hospital Boards; hence they draw patients from anywhere, and do not have to compete with service hospitals for funds. The only large psychiatric institution used as a teaching hospital was the Bethlem Royal and Maudsley, which is in the Southeast Metropolitan Region.

In 1960 the total National Health Service bed capacity was 475,409—including more than 200,000 psychiatric beds. The beds are located in 2,688 hospitals, 358 of which are psychiatric. In 1960 England and Wales had 10.3 hospital beds for each 1,000 population. This is somewhat less than the Canadian and American ratio, yet the British Government expects to reduce it to 8.5 per 1,000 by 1975—mostly by reducing beds for the mentally ill.

The 10.3 beds per 1,000 now break down as follows:[1]

Acute	3.9
Geriatric	1.3
Maternity	.45
Mental Illness	3.3
Mental Subnormality	1.3
	10.3

In 1959-60, the total cost of the National Health Service[2] was £726,500,000. The weekly cost for each mentally ill patient was £8 7s 5d, with patients in hospitals for the treatment of subnormality costing almost a pound less. In sharp contrast, the weekly cost for physically ill patients in non-teaching hospitals was £27 16s 11d, with the teaching hospitals running almost £12 a week higher.[3] From this it is apparent that, despite a recent improvement in the standard of psychiatric care, the British still allocate much more money for the treatment of physically ill patients. Some authorities insist that the treatment of mental illness should cost less because 75 per cent of mental hospital patients are chronically ill; this does not explain why patients with chronic physical illness fare better than do the mentally ill; in England and Wales the treatment of the chronic sick costs £11 14s 3d per week, and the treatment of geriatric patients costs even more. Thus it is apparent that the mentally ill still receive the cheapest care.

It is not easy to use cost figures to compare standards of care between Britain and Canada, but some comparison is possible. Even allowing for differences in cost-of-living in the two countries, more money per patient is spent in Canada than in Britain; this applies both to the physically sick and to the mentally ill.

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[1] *A Hospital Plan for England and Wales*, London: Her Majesty's Stationery Office, January 1962.

[2] *Report of the Ministry of Health* (1960), Parts I and II, London: Her Majesty's Stationery Office, July 1961 and December 1961 resp.

[3] Brook, Eileen M., personal communication.

When, in 1948, the National Health Service acquired all the voluntary and municipal hospitals, most of the buildings were obsolete—especially the former municipal hospitals (often workhouse infirmaries) and the mental hospitals. By 1961, capital expenditures for modernization had exceeded £ 20,000,000 a year, and this is to be further increased in future. This program of modernization included the mental hospitals, and during the past 10 years much has been done to make these institutions more attractive. Improvements in mental hospitals have included papering and decorating the wards, covering cement floors, lighting dark corridors, and adding comfortable and attractive furniture. Except for a few special items, all capital allotments and all operating funds come directly from the National Exchequer.

In Britain (in contrast to Canada) a hospital medical staff is almost exclusively made up of specialists. In the National Health Service (in England and Wales), there are 7,416 specialists at the consultant rank—including 702 consultant psychiatrists. The consultants may be full-time, or part-time with private practice privileges; some psychiatrists are in part-time private practice. In addition to the 702 consultant psychiatrists, there are also 810 registrars, and more than 200 senior hospital medical officers, employed by the regional hospital boards to work in psychiatry.

The 702 consultant psychiatrists include less than 10 per cent of the specialists in Britain, yet look after more than 40 per cent of the hospitalized patients. The explanation of this discrepancy lies in both the excessive number of chronic patients in mental hospital, and in the smaller number of specialists available in psychiatry; whereas 40 per cent of all the patients in England and Wales are in psychiatric hospitals, these institutions have only 3 per cent of the total hospital admissions.

2. Mental Hospitals[1]

(a) *General Considerations*

There are 358 psychiatric institutions within the National Health Service. These are as follows:

Psychiatric Institutions	Number of Patients
144 Hospitals for the Mentally Ill	139,083
211 Hospitals for the Mentally Subnormal	59,521
3 Maximum Security Institutions for the Mentally Ill and for the Mentally Subnormal	2,113
	200,717

In addition to beds listed above, there are 4,642 beds in psychiatric units in general hospitals; furthermore most medical wards in general hospitals contain some patients diagnosed as physically ill who are actually mentally sick.

The 144 mental hospitals in Britain vary in size from 13 institutions that have less than 100 patients to six with more than 2,500. With 3,077 patients, the largest is at Whittingham in the Manchester Hospital Region, whereas the

[1] Tooth, Geoffrey, "The Psychiatric Hospital and its Place in a Mental Health Service", *Bulletin WHO*, 1958, 19, 363-387.

average hospital has about 1,100 beds. In comparison with North American institutions, these hospitals have remained small—partly because they serve, for the most part, only the municipality in which they are located.

Most British mental hospitals are old, with 21 per cent built over 100 years ago; no new ones have been constructed since World War II, and since 1918 only two new hospitals and a few annexes have been added.

Mental hospital architecture has changed little during the past 100 years. Designed for security and economy (with long corridors and big wards), most mental hospitals today are better suited for custody than for therapy; most were built according to a plan devised in the mid-nineteenth century, at a time when the builder's chief concern was to protect the public from dangerous people, rather than to make mentally sick people well. Thanks to recent improvements, British mental hospitals are now usually more attractively furnished, and much more homelike than most mental hospitals in Canada and in the United States.

In an effort to keep the insane out of populated areas, most mental hospitals were originally located in isolated spots. Thus usually working at some distance from important medical centers, mental hospital physicians still have but limited communication with other doctors. In an attempt to overcome this professional segregation, the physician superintendent of the Lancaster Moor Hospital (in the Manchester Hospital Region) has added a neurosurgical unit, a geriatric service, an ophthalmic unit and a long-stay orthopaedic unit; these are a part of the general medical service of the area. Perhaps more such integration would bring psychiatry nearer to general medicine.

During the past 25 years, most British mental hospitals became increasingly overcrowded, with the worst overcrowding being reached in 1954. Since 1954, this overcrowding has decreased, and the Ministry hopes that, during the next 15 years, it will be able to reduce the number of mental hospital beds by 40 per cent.

During 1959, in England and Wales, 105,742 patients were admitted to mental hospitals—55,407 for the first time. This was a 44 per cent increase in the annual admission rate—in a five-year period; it reflects the changing picture, indicating in part, a better public acceptance of the mental hospital. Of the patients admitted during 1959, 88 per cent entered hospital voluntarily—further evidence of increased public acceptance. Disturbed by the spectre of overcrowded wards, many British psychiatrists are now trying to restrict admission, and to treat more persons as out-patients. Atkin[1] suggests that an effort should be made to reduce admission by:

(i) only admitting a patient if
    (a) the necessary treatment required hospital admission, or
    (b) if the patient's behaviour is such as to render him potentially dangerous to himself or others, or very troublesome to his family or to society,
(ii) increasing out-patient department services,
(iii) avoiding admitting patients for social reasons,
(iv) providing more beds in chronic sick units and in welfare homes,
(v) providing special units for aggressive psychopaths.

[1] Atkin, I., "Why Admit to Mental Hospital," *B.M.J.*, Jan. 31/59, pp. 293-296.

An increase in re-admissions of from 36,000 to 50,000 (1955-1959) has more than matched the admission increase. Some critics of present trends insist that this increase in hospital re-admissions denotes the failure of the policy of early discharge, but most authorities believe that a truer explanation lies in the closer links being established between the hospital and the community; both admission and discharge are now easier and more acceptable.

Among newly admitted patients, neurosis has become one of the most common diagnoses (20 per cent of all admissions); this is a change from 30 years ago when neurosis was seldom diagnosed in mental hospital, and it also implies greater public acceptance of the mental hospital (more patients admitted with mild complaints).

(b) *Mental Health Act—1959*[1]

The Mental Health Act of 1959 clarifies present policy, and re-defines the authority for admitting mentally disordered patients to hospital. Departing from the usual practices governing mental hospital admission in the United Kingdom and elsewhere, the Act creates legislative authority for the radical changes that are now taking place in British psychiatry. The transition from asylum custody to treatment in hospital required the authority of a new Act which, in effect, serves as a new policy directive.

The Mental Health Act of 1959 came directly from the report (published in May 1957) of the Royal Commission on Law Relating to Mental Illness and Mental Deficiency, but much of the policy that patterned the Act was worked out during the preceding ten years by the staff of the Board of Control under the leadership of Dr. W. S. Maclay.

Those who planned this legislative change tried to humanize psychiatric care by making mental treatment a medical procedure rather than a judicial process. They hoped that mental patients could be admitted to hospital with the same ease and the same absence of red tape that marks the admission of the physically ill. It was thought that this would remove some of the stigma that has created a psychological bar to early treatment, as well as granting the patient greater control over his own activities.

In the preparation of its report, the Royal Commission on Law Relating to Mental Illness and Mental Deficiency[2] spent three years listening to briefs, and the Act, when passed, included most of the Commission's recommendations. Those who wrote the Act, however, did amend one of the Commission's suggestions on nomenclature. The Royal Commission had recommended that mental disorder be classified under three main categories:

(i) the mentally ill,
(ii) the severely subnormal, and
(iii) the psychopath.

Under the psychopath, the Commission meant to include not only those who have been traditionally called psychopaths, but also those high-grade mental defectives requiring institutional care. This policy of listing all high-grade mental

[1] "Summary of the New British Mental Health Bill", *Canada's Mental Health, Supplement*, (April 1959).

[2] *Royal Commission on Law Relating to Mental Illness and Mental Deficiency, 1954-1957*, London: Her Majesty's Stationery Office (1957).

defectives under the term psychopath was not acceptable to the Ministry, and so, for this group, a fourth category termed the "subnormal" was added.

As a first step towards treating mental disorder in the same place as physical illness, the Act cancelled (dedesignated) the special status of all psychiatric beds. Formerly, beds to which certified patients could be admitted were designated as such—no matter whether in mental or general hospitals. As a result of this change, any psychiatric patient could be admitted to any bed in any hospital as long as the administrator of that hospital was prepared to accept him. This even made it legal to admit general medical patients to mental hospitals, wherever desirable.

Within a year after the Act authorized informal admission of mental patients, many mental hospitals were admitting 90 per cent of their patients without special documents; unless a patient actively resisted, he was admitted informally. At the same time, legislation was provided for patients who had to be admitted involuntarily; here an elaborate system of safeguards was established to protect against the old bogey of wrongful incarceration, which had led to the Lunacy Act of 1890. Twenty per cent of all hospital patients still entered hospital involuntarily; as soon as their mental condition permitted, most could be transferred to informal status. Between 1930 and 1960, British mental hospitals changed from 100 per cent compulsory admission to more than 80 per cent voluntary admission, with great benefit to hospital morale.

Under the Mental Health Act of 1959, an application to a hospital management committee for the admission of a disturbed unco-operative patient may be made either by a relative, or by a mental welfare officer; where possible, support for this admission is obtained from the relatives. Even without a relative's permission, the mental welfare officer can arrange an emergency admission on one physician's recommendation (good for 72 hours) or for a period of observation on two physicians' recommendations (good for 28 days). If it is considered necessary to admit a patient for treatment that will last longer than 28 days, two medical recommendations and the permission of a relative or guardian become necessary. If the relatives object unreasonably, the County Court can be asked to transfer guardianship to some other person, who could be a member of the staff of the Local Authority.

If he so desires, a patient admitted against his will may, six months after admission, apply to an Appeal Tribunal, and, if it sees fit, this Tribunal can discharge him. The Act had created the Appeal Tribunal to take over one of the functions of the Board of Control, which it had abolished. A Tribunal was established in each hospital region with its members including both professional and lay persons. Authority to hold a patient for treatment lasts only one year and must be renewed at stated intervals; during the first two years of the Act's operation 741 patients in English and Welsh mental hospitals have applied to Appeal Tribunals requesting discharge; 86 of the appeals were upheld.

Mindful of civil rights, safeguards were provided in the Act lest the compulsory powers be used to permanently segregate the annoying high-grade defective or psychopath. Unless admitted on a court order, members of these two categories may be admitted involuntarily only if under 21 years of age, and must be released by age 25 unless considered dangerous (differing from the mentally ill and severely subnormal who may be admitted involuntarily at any age).

If psychiatric treatment appears indicated, a Court may authorize either hospital admission or guardianship for patients appearing before it. A judge may

send a patient to a mental hospital only if the superintendent agrees to receive him. Authority for the patient's care, treatment and discharge is the same as for any other patient admitted to mental hospital—except that:

(i) his relatives cannot demand his discharge, and
(ii) if the judge considers the patient dangerous, he can place some restriction on his discharge.

Most superintendents dislike receiving this type of patient, whom they believe frequently require custody rather than therapy.

Most British psychiatrists are pleased with the Mental Health Act of 1959, even though understandably most dislike one or other feature of it. This Act should lead to similar legislative reform in other countries; already one Canadian province (Saskatchewan) has passed new legislation based on the same principles.

(c) *Staff*

(1) *Administrative*

The National Health Service Act of 1946 changed psychiatric services in two important ways:

1. Located within the superstructure created by the National Health Service Act of 1946, the 358 mental hospitals were required to adjust to an administrative pattern that was actually set up for the more than 2,000 general hospitals; many changes in mental hospital operation have resulted.

2. Governed by policies established by a central Ministry, the hospitals are operated by local volunteer boards (regional hospital boards and hospital management committee) with funds coming from the national Treasury.

The responsibilities of a physician superintendent in Britain today are quite different from the responsibilities of his predecessor twenty years ago. No longer is the superintendent the independent head of a hospital hierarchy; although still chief spokesman for the medical staff, he has ceased to be its master (some hospitals have replaced the Medical Superintendent by a Chairman of the Medical Committee). Although paid extra for assuming administrative duties, he holds the same consultant rank as do two or three other senior staff members. Compared to former mental hospital chiefs, the physician superintendent today is much more active clinically; he often directs mental health clinics, or carries out domiciliary consultations—for which he receives four guineas a visit. Most of the superintendent's former maintenance and business responsibilities have been transferred to a lay business administrator (*cum* business manager), who is also secretary to the hospital management committee. It is still to some extent true that the character and personality of the individual superintendent determine the degree of authority and responsibility that he exercises (certainly Macmillan at Mapperley and Bell at Dingleton exercise more authority and personal initiative than do many other superintendents).

The superintendent is the chief spokesman for the institution in the community, but in the meetings of the hospital management committee he shares some of this responsibility with the group secretary. As the business manager, the group secretary superintends the hospital's maintenance, and oversees how its money is spent. In co-operation with the physician superintendent, he

prepares the next year's budget and presents it for approval to his hospital management committee. The mental hospital group secretary must operate within a budget which, on the average, provides £8 7s 5d per week per patient, with the hospitals for subnormals operating on about a pound per week less. Despite attempts to improve standards in the treatment of the mentally ill, the secretary of the general hospital still has three times as much money to spend on each patient suffering from acute physical illness as his mental hospital counterpart can spend on mental patients.

Why did the Ministry adopt this system of committee management, and why did it place its institutions under the dual authority of a physician superintendent and a group secretary, and how well does this work? The Ministry set up these lay hospital boards in its efforts to secure local participation. Fearing domination of the lay boards by powerful medical administrators, the Ministry countered by granting status to the business managers that equals that of the doctor; since practising physicians have traditionally eschewed administrative responsibility, the voluntary hospitals had already established precedent for lay control, and since mental hospitals sought parity with general hospitals, it seemed wise to grant them the same administrative structure.

How well has the system worked? The mental hospitals have not yet achieved equality with general hospitals in financial resources and prestige, but the situation is improving; certainly local interest in mental hospitals has increased, and there is much more local participation in their operation. Almost every superintendent with whom I talked told me that because his secretary was an unusually good one, the division of responsibility with the group secretary was working all right in his hospital, but that he was against this dual authority on general principles. Most of these superintendents still thought that the Medical Superintendent should be in charge. They admitted that the State's former overconcern about protection no longer interfered with the clinical aims of the psychiatrists, but feared that bureaucratic control might; this latter sentiment was expressed more as a fear for the future than as a present reality, and I heard little complaint about bureaucratic interference.

Several times monthly the physician superintendent and the group secretary report jointly to the hospital management committee at its regular meetings; usually the matron and the chief male nurse also report to this committee. The committee comprises about 15 members and includes representatives from local lay and professional groups. The committee concerns itself chiefly with staff appointments, structural changes, and policy recommendations to the regional hospital board; it leaves the day-to-day administrative decisions to the superintendent and to the group secretary. Although this arrangement works reasonably well in Britain, without considerable modification it might not work in Canada.

There are about 400 hospital management committees in Britain—an average of one committee to eight or nine hospitals. Since mental institutions are usually large (compared to other hospitals), many committees run only one psychiatric hospital, whereas others run one or more—together with an adjacent hospital for subnormals. To move psychiatry closer to medicine, instead of grouping all of their mental hospitals under one hospital management committee, one or two regional boards have distributed their mental institutions among groups that also administer acute and chronic hospitals for the physically ill.

Each regional board serves a population of from 1,500,000 to 4,500,000 people. Regional hospital boards are appointed by the Minister, and are made up

of local citizens who serve without pay. In contrast with the hospital management committee, which is concerned with the everyday operation of the hospital, the regional board devotes its attention chiefly to planning, budgeting and capital construction. It amends and approves budgets submitted by its hospital management committees, and forwards the total request to the Ministry. Even without Ministerial approval, the region can spend up to £50,000 on capital costs, permitting some local initiative in the use of central funds. This leeway extends only to capital funds, and the regional hospital board is permitted no discretion with salaries. To get a fair agreement between staff and management and to prevent one regional board from bidding against another for staff, a central authority known as the Whitly Council negotiates the salary scale for all National Health Service employees (including physicians); the regional board must pay according to these national rates.

Since the regional hospital boards devote much time to long-term planning, they have all contributed to a monograph which presents the Ministry's blueprint for future hospital services; this publication, which was released in January 1962, is called "A Hospital Plan for England and Wales".[1] It outlines plans for hospital building up to 1975, and describes how, during the next 15 years, the total number of mental hospital beds could be reduced from 140,000 to less than 90,000. It discloses plans to modernize existing hospitals—including many mental institutions (some mental hospitals are to be scrapped entirely); according to the Plan all regions expect to add psychiatric beds to some of their general hospitals.

Through its policies and plans, the Ministry strives to improve its regional services. In formulating national policy, it is frequently influenced by developments occurring in these regions; what has happened in Chichester, Nottingham, and more recently in Manchester, has since been reflected in Ministerial decisions. Some of the Ministry's policies are still to be tested, whereas others have passed the experimental stage. The principle established by the National Health Service Act of 1946 of central financing and policy-making combined with local operation seems to work well, and could be usefully tried out in Canada.

(2) *Medical*

Whereas a psychiatrist on the staff of a Canadian mental hospital stays close to it, on the other hand a psychiatrist in the British mental hospital spends much time away doing community work. The British practice of having mental hospital staff conduct clinics in general hospitals began with the Mental Treatment Act of 1930. On the authority of the National Health Service Act of 1946, many mental hospitals hired part-time consultants who also engaged in private practice. On the request of general practitioners, both full-time and part-time consultants carry out domiciliary visits for which the regional hospital board pays at the rate of two guineas a visit. To control the cost of this domiciliary visiting, the full-time consultant receives no pay for his first eight domiciliary calls in any three-month period, and all consultants are restricted to a total income of £800 annually from this source.

In part, these favourable financial arrangements for the medical staff indicate the improved status that psychiatry achieved when granted equality within the National Health Service. As a result, morale among psychiatrists is

[1] *A Hospital Plan for England and Wales*, London: Her Majesty's Stationery Office, January 1962.

much better in British than in North American mental hospitals. Not only does the greater opportunity to work in the community make the British mental hospital staff more independent, but also means that mental hospital psychiatrists in Britain exercise more leadership in the growth of psychiatry throughout the nation, than do their counterparts in America. Such mental hospital superintendents as Macmillan, Carse, Bell and Mandelbrote (to mention only a few) have had more constructive influence on psychiatry than most leaders in British medical schools, and much more influence on changes in world psychiatry than mental hospital psychiatrists in other countries.

Group effort of British psychiatrists is expressed through the Royal Medico-Psychological Association; formed in 1841, this organization now has 2,000 members. Its interests include the welfare of psychiatrists in training as well as improving methods of psychiatric treatment. The Association played an active part in the creation of the Mental Health Act of 1959. It now publishes the *British Journal of Psychiatry*—formerly called the *Journal of Mental Science.*

(3) *Nursing*

At the present time there are 21,210 persons (including students) engaged in full-time psychiatric nursing in England and Wales, and 7,164 in part-time nursing; for Britain's total of more than 200,000 patients, this is less nursing staff than in Canada.

Those responsible for psychiatric nursing in British mental hospitals strive to keep recruitment and training at a high standard. An educational level equivalent to Canadian Grade XI is required by all qualified recruits, and to become registered mental nurses, students must successfully complete a three-year training program in a mental hospital. During training, psychiatric nursing students receive about £ 300 a year, and graduates are paid from £ 600 to £ 800; both are paid better than their counterparts in general hospitals. Due to sharp competition from industry, it is hard to obtain enough qualified recruits—especially female. Fortunately, since the War, immigrants from the Commonwealth and from Europe have filled many vacancies; with the image of psychiatry now looking better, prospects for improved recruiting seem bright.

The Ministry's stated plan to integrate psychiatry into general hospitals has been blamed for some of the difficulty in recruiting to mental hospitals; to alleviate staff anxiety about job security in mental hospitals, the Minister has recently suggested that the more active programs planned for short-stay patients, and the more extensive community programs, will in the future create even greater opportunities than are now available for the mental hospital trained nurse.

A 30-year battle between the General Nursing Council and the Royal Medico-Psychological Association ended 12 years ago when the General Nursing Council gained control of the training program; the GNC thus secured the privilege of determining the curriculum and carrying out the examinations. Recently the Council increased the amount of psychiatry taught in the course, and reduced some of the time allocated to other subjects.

The history of psychiatric nursing touches many of the struggles which have occurred in British psychiatry. Until 150 years ago when the mentally ill were transferred from jails and almshouses to asylums, the keepers of the insane were a poor lot indeed. In 1792, in the city of York, the Tukes made the first successful effort to attract high-calibre staff and to provide good training. By 1842 many

mental hospital superintendents realized the need for trained staff, and by 1885 the Royal Medico-Psychological Association (by then in full control of psychiatric training) had produced its famed *Red Handbook* of instruction for psychiatric nurses. In one of its few worthwhile achievements, the Lunacy Law of 1890 authorized compulsory training for mental hospital nurses.

Many psychiatric nursing posts in Britain require nurses with dual training; this may be secured either by a registered mental nurse, having completed her three years in mental nursing, taking an additional two years in general hospital nursing, or by a State registered general nurse, having completed three years in a general hospital, taking an extra year and a half of training in a mental hospital.

As a rule, the mental nurse assumes most of the responsibility for the therapeutic milieu, which is now so important in modern British mental hospitals. In such institutions as Littlemore in Oxford, the nurses encourage informal ward relationships by themselves wearing civilian clothes rather than uniforms.

Although the British have integrated male and female patients in occupational and recreational activities, male and female nursing staff remain administratively separate; both the matron and the chief male nurse report directly to the superintendent and to the hospital management committee.

(4) *Social Work*

Like mental hospitals everywhere, British mental hospitals have few qualified psychiatric social workers; administrators clamour ineffectually for more. Many explanations have been advanced for this scarcity—including poor pay and unreasonably high educational standards. The Mackintosh Report of 1951 noted[1] that, up to that time, a total of 523 qualified psychiatric social workers had been trained, but only 55 were then employed in mental hospitals, and only eight in the psychiatric services of the local authorities. Although more than 1,000 psychiatric social workers were needed immediately, Professor Mackintosh pointed out that the training resources available in 1951 could produce only 70 fully qualified persons each year.

In 1959, the Younghusband Report[2,3] presented additional information on psychiatric social workers. During the intervening eight years (since the Mackintosh Report) the number of qualified psychiatric social workers in local authority services had increased only from 8 to 26; there were by 1959, 211 social workers working in mental hospitals, and 165 in mental health clinics (including child guidance clinics).

To meet the urgent needs, the Younghusband Report recommended setting up a crash program to train three types of social service worker:

(i) a fully qualified teaching and administrative group,
(ii) a much larger group trained in a shorter program in college courses, and

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[1] Titmus, R.M., *Community Care—Fact or Fiction—Emerging Patterns for Mental Health Services and the Public*, Conference NAMH, London, March 1961, pp. 66-70.

[2] *Ibid.*

[3] *Report of the Working Party on Social Workers in the Local Authority Health and Welfare Services*, London: Her Majesty's Stationery Office, 1959.

(iii) a group of social work assistants with in-service training.

How well these training needs for social workers can be met is a good question. The British tradition in social welfare has a long history; caring for the less fortunate is part of the British ethic, and its roots rise both from the monks of the medieval monasteries, and from the nineteenth century Fabians. The first course in social work was given in the London School of Economics, which fostered Lord Beveridge, and where Professor R. M. Titmus and Professor Eileen Younghusband now hold sway.

The new emphasis on early discharge and community treatment is changing social work practice in British mental hospitals. Much closer liaison is now required between the mental hospital and the mental welfare officers of the local health authorities. The present scarcity of trained psychiatric social workers makes it hard to predict who, in future, will look after discharged patients. If the Ministry is to succeed in its plan to reduce mental hospital population, and to treat more psychotics in general hospitals and in the community, it will need many more competent community workers, both to help the discharged patients, and to support their families. At present, the relatively untrained mental welfare workers, and in some cases the visiting nurses, do most of the community follow-up; so far in most areas there has been poor liaison between those workers and the fully trained professionals. In the town of Salford in the Manchester Hospital Region, the mental welfare workers were temporarily removed from hospital clinics because the qualified social workers had complained about their use. Who is to do the follow-up of discharged patients? This is one of the most difficult problems facing psychiatry today in Britain (and elsewhere).

(5) *Psychology*

Neither mental hospital administrators, nor the psychologists themselves, have satisfactorily defined the role of psychologists in British mental hospitals. The psychologists seem to play a larger part in the hospitals for subnormals, where their experience with learning theory is proving useful. Some superintendents regard psychologists as psychometricians, others as researchers, and a few have the psychologist taking part in treatment. So far, the number of psychologists in British mental hospitals is limited; whether the trends toward more community treatment will change what the psychologist does cannot be clearly discerned—yet.

(6) *Occupational Therapy*

The great increase in therapeutic activity on the wards of British mental hospitals has required more occupational therapists, recreational therapists, music therapists and other specialized workers; many of these have been recruited from the ranks of the nursing staff. The number of fully qualified professional occupational therapists has increased, and in some mental hospitals occupational therapists have been put in charge of the expanding industrial therapy program. In other hospitals, however, believing that the specialized training of the occupational therapist handicaps her in directing activities that are primarily industrial, superintendents have preferred to have occupational supervisors whose training was practical rather than theoretical. Since industrial therapy programs are likely to continue and to expand, many administrators suggest that in future educators should produce professional occupational therapists better prepared to assume responsibility for industrial therapy programs.

(d) *Treatment Trends*

In the British mental hospital today, the psychiatrist's chief aim is to resocialize his patient, and to return him, as quickly as possible, to the community. No longer considered a colony for permanently handicapped persons, the mental hospital is fast becoming a temporary refuge in which (hopefully) the patient is quickly made fit again before moving back into his former surroundings.

To permit faster flow in and out of the hospital, British superintendents are breaking down the mental hospital walls.[1] Despite a great increase in admissions to the Ailsa Hospital in Ayrshire, Dr. Braun-Miller has reduced his patient population by doubling his discharge rate; patients, newly admitted to his hospital, are discharged after an average stay of only three weeks. The Ailsa pattern illustrates the general trend in the United Kingdom. When accepting a new admission to the Mapperly Hospital in Nottingham, Macmillan warns the relatives to expect the patient home within four weeks, and seldom does he need to extend this deadline.

The everyday activities of patients in hospital are organized in a manner meant to increase the chances of early discharge. The newly admitted patient is quickly accepted as a member of a vigorous community; at the Littlemore Hospital in Oxford, a representative of the patients' welcoming committee meets him at the door when he first arrives. This enthusiastic acceptance helps eliminate those feelings of rejection that have so often resulted from the reaction to his illness of both his family and of the community.

Since therapy depends so much on organized activity, British psychiatric nurses play a most important role in treatment, and compared with nurses in Canadian mental hospitals, are given greater responsibility for occupational and recreational therapy. Since discharge usually means going to a job, the emphasis in hospital is on useful activity. As described above in the comments on Glenside in Bristol, many centers are establishing programs in which patients are paid for the work they do in hospital. It is hoped to amend the current legislation requiring the patient to contribute to the National Insurance Fund once his earnings exceed two pounds weekly. This increased activity has benefited the long-stay patient as well as the new admission. Between 1950 and 1960, the Glenside Hospital increased by 400 per cent the annual discharge rate of patients who had been in hospital for longer than 12 months.

Although used extensively, the ataractic drugs rate much lower in Britain than in America. Most British psychiatrists think the tranquilizers help the resocializing process, but are by no means the most important factor; Shepherd[2] presents concrete evidence in support of this view. As Bell has shown, the improvement in the Dingleton Hospital started well before the drugs appeared.

Other physical treatments are used less now than formerly. Electrotherapy remains the mainstay for psychotic depression, but is not used much for schizophrenia; some psychiatrists will speed recovery from neurotic depression by administering a few electric shock treatments. Lobotomy has almost disappeared.

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[1] Baker, A. A., "Pulling Down the Old Mental Hospital", *The Lancet*, March 25, 1961, pp. 656-657.

[2] Shepherd, Michael, Goodman, Nancy, and Watt, David C., "The Application of Hospital Statistics in the Evaluation of Pharmacotherapy in a Psychiatric Population," *Comprehensive Psychiatry*, Vol. 2, No. 1, February 1961.

With so much more stress on making psychiatry part of medicine, psychiatric patients now receive better general medical care. In Edinburgh, Dundee, and Dumfries, I met geriatricians who had helped set up excellent facilities for physical diagnosis and treatment in mental hospital. In many centers in the Manchester Hospital Region, confused old people who are physically ill receive treatment in geriatric units—rather than in the psychiatric wards. So psychiatry inches closer to its proper place in the practice of medicine.

Compared with its status in America, individual psychotherapy has a low rating in Britain; many British psychiatrists consider psychotherapy to be mostly a supportive procedure, and so interviews are brief and directive. Freud is honoured for his contributions to theory rather than to treatment. In fact, group psychotherapy is more frequently used than individual psychotherapy, not only because it requires less staff, but also because it better fits the current pattern of togetherness.

To keep patients under treatment in better touch with their homes, more day centers have been established—with local authorities providing transportation. These day centers help reduce the number of hospital beds; volunteer groups also help resocialize patients. The League of Friends provides volunteer visitors who (as in Canada) bring the community to the hospital, and the hospital to the community. They support social clubs for patients; these social clubs were first formed by Bierer twenty years ago at the Runwell Hospital, and have contributed a great deal to psychiatric treatment and rehabilitation.

During the past two decades, psychiatrists have made a vigorous attempt to convert the British mental hospitals from custodial to therapeutic institutions. To accomplish this they have:

(i) changed the mental hospital goal from one of providing comfortable quarters for sheltered care to one of re-establishing the mentally sick in the community;
(ii) made possible easy and informal admission—with quicker discharge;
(iii) improved communications between the hospital and the community;
(iv) insisted that the patient's activity in hospital be directed towards preparing him for life outside.

The remnants of the custodial era are disappearing. Physical restraints are gone, and doors are being unlocked. Purposeful activity has replaced not only the dreary parades through airing courts, but also the marching lines of blank-faced men pushing floor polishers. Buildings are now being modernized and the surroundings made more attractive.

3. Psychiatric Services in Scotland

When one crosses the River Tweed, the differences between England and Scotland become clearly evident—even in psychiatry. The change in the picture arises from differences in race, culture, religious denomination (with some of the spirit of '45 to boot). Under the National Health Service, hospital care for the 5,184,000 Scots is administered through five regional hospital boards.[1] Four of these boards are centered in the university cities of Glasgow, Edinburgh, Dundee and Aberdeen, and the fifth, serving the north of Scotland, is at Inverness.

[1] *Hospital Plan for Scotland*, Edinburgh: Her Majesty's Stationery Office, January 1962.

Scotland's mental hospitals are generally smaller than those in England and Wales; they have usually from 600 to 800 beds. Unlike most of their English counterparts, many Scot psychiatrists spoke of their mental hospitals with pride, and from what I saw there is some reason for this pride. Certainly the three Scottish hospitals that I visited (Dingleton, Ailsa and the Crichton Royal) were attractive (as mental hospitals go), and their patients were neat and well cared for. As mentioned elsewhere, the Dingleton Hospital had pioneered the open door; in addition to having almost all of his patients up and dressed, Dr. Braun-Miller at Ailsa near Ayr, had an excellent program for rehabilitating his newly admitted patients through early placement on nearby farms.

I found some striking differences between the mental hospitals in England and Scotland. It appeared that the latter were more self-sufficient than those south of the border, and more separated from the general hospitals, and from the general physicians. This could be explained in part by the more sparsely settled rural areas, and by the presence in Scotland of a higher ratio of cottage hospitals—instead of larger general hospitals. Mental hospital superintendents in Scotland seemed to exercise more authority than did physician superintendents in England; one wonders whether the more ready acceptance by the Scots of hierarchical arrangements stems from their not too remote experience with clan discipline.

The number of mentally ill patients in hospital is higher in Scotland than in England. There are 12,811 beds in Scottish mental hospitals, making a ratio of 4.2 per 1,000 population, compared with 3.3 per 1,000, in England and Wales. The 5,572 mental defectives in institution make a ratio of 1.1 compared with 1.3 in England and Wales. One possible explanation for the higher ratio in Scottish mental hospitals is a higher proportion of old people in the population, and a shortage in the community of alternative facilities for looking after older persons.

In January 1962, the Secretary of State for Scotland issued a monograph entitled, *Hospital Plan for Scotland*,[1] which when compared with the hospital plan for England and Wales, revealed some of the differences between the two areas. The Scottish monograph pointed out that mental health authorities in Scotland do not anticipate an early decline in the number of patients in their mental hospitals. In contrast to all other categories of hospital beds, no estimate was made in the report of the future needs for the mentally ill. It was said that in Scotland, within the next 10 years, beds for mental defectives would be increased from 5,572 to 8,535, with the anticipated ratio being 1.5 per 1,000 (compared to 1.3 per 1,000 planned in England).

One gets the impression that this reluctance to predict future needs for psychiatric beds reflects a lack of enthusiasm for the trends developing in England and Wales. In Scotland more psychiatrists want to retain the mental hospitals; one superintendent told me that the English should get rid of their mental hospitals because they were such poor institutions, but that the situation in Scotland was very different. I wondered whether the reluctance to accept plans drawn up in England might not be due to nationalistic pride as well as professional differences in opinion.

The Scottish wish to be different was reflected in other ways. In England the new Mental Health Act came into effect in October 1959, whereas the Mental Health Act in Scotland (1960) was not effective until May 1961. The Scottish

[1] *Ibid.*

Act retains the term mental deficiency, making no distinction on grounds of severity. There is no grouping in the Scottish Act for the psychopath, although there is provision for patients with dangerous, violent or criminal tendencies. The English have done away with judicial authority, but in Scotland the sheriff must approve compulsory admissions. Appeals against compulsory admission in England are handled by a Regional Tribunal, whereas in Scotland they are considered by the Scottish Mental Welfare Commission.

There seems to be less enthusiasm in Scotland for integrating psychiatry with the rest of medicine. On the whole, consultant psychiatrists in Scotland have less to do with the general physicians, and there is less domiciliary visiting (greater distances influence this). Although there is talk of building 80- to 100-bed psychiatric units as part of some of the larger general hospitals (in Paisley there is an actual plan to build a large comprehensive hospital with about half of its beds for psychiatry), by and large there is less enthusiasm in Scotland for adding psychiatric beds in general hospitals. This is partly due to the number of small cottage hospitals in active service. On the other hand, there is a serious suggestion in Scotland that the mental hospitals may add general beds to serve non-psychiatric patients in the community, and so integration might come about in this way. Despite the very great number of old people in some mental hospitals, both Edinburgh and Dundee have excellent geriatric services, which admit and treat many psychotic old people.

In the large cities of Scotland, co-operation seems good between the mental hospital psychiatrists and the Local Authorities. Edinburgh has a model set-up with its 100 visiting nurses being made most welcome in the city's psychiatric hospitals. These nurses attend mental hospital staff conferences, and an excellent community follow-up service is now taking shape. Local Authorities in Scotland now spend about £45 per 1,000 population on mental health, compared to twice as much (per 1,000) in England and Wales, but the Scots are planning big increases for local mental health projects.

To sum up: it is hard to find a consistent pattern of difference in the psychiatric services of Scotland compared with those in England, but there is some difference. Despite less integration with the general hospitals, Scottish mental hospitals play a bigger part in community life. The mental hospital staff in Scotland appears to have less contact with general physicians than in England, but more contact with the local health authorities. The stigma associated with the mental hospital is less in Scotland, but it still exists. One big difference between the two countries is a stronger conviction in Scotland that the mental hospitals should, and will, persist as separate units. Compared with England, Scotland displays a greater tendency to treat patients in hospital than in the community.

4. Medical Education and Psychiatry

(a) *Undergraduate*

Of all the topics that I discussed during my six weeks' visit to Britain, I found the greatest agreement on one—that something must be done to improve the country's undergraduate medical education in psychiatry. Since my survey deals primarily with trends in service, I visited only three medical schools, and talked to only two heads of undergraduate Departments of Psychiatry; nonetheless I heard much talk on psychiatric education, although found little recorded

information. In comparison with teachers in North America, British psychiatrists have published little concerning undergraduate psychiatric teaching; thus in regards to teaching, this survey will contain more personal impression than established fact.

In 1959, the British Medical Students Association published the results of a survey it had made on the teaching of Psychiatry and Psychological Medicine; this survey pointed out some of the shortcomings in the teaching of psychiatry in British medical schools. Seventeen medical schools co-operated with the students making the study (6 of 12 London schools submitted no information). At the time of that survey, only 6 of the 17 schools had Chairs in psychiatry; in only 1 of the 17 was there a final examination—5 have no examination in psychiatry of any sort. The number of lectures given on psychiatry during the medical course, varied from 7 to 32; less than half of the students were exposed to in-patient psychiatric rounds. Three-quarters of the students thought their training in psychiatry was too brief; many of those who thought it long enough, believed they got little from it. The British Medical Students Association recommended:

(i) pre-clinical training in psychiatry,
(ii) integrating psychiatric teaching with medicine,
(iii) more out-patient and in-patient undergraduate experience in psychiatry,
(iv) more training on those common mental disorders that take up so much of the practitioner's time, and
(v) compulsory examinations.

Undergraduate teaching in psychiatry has improved a little during the four years since the students issued their report. Several medical schools, including Birmingham, have since established Chairs in psychiatry, and other schools will add Chairs soon. Despite these changes, psychiatrists, general physicians and others interested in mental health still complain bitterly about the lack of undergraduate psychiatric training. Most of those who complained believed that general physicians must play a larger part in psychiatry in future, and they feared that medical schools now prepare their students poorly for this.

The reasons given by many psychiatrists for the low status and limited impact of psychiatry in British medical schools (compared with North American medical schools) included:

(i) too little time available for teaching psychiatry in the already overcrowded curricula,
(ii) over-emphasis on medicine and surgery (compared with psychiatry),
(iii) a lack of scientific data in psychiatry,
(iv) actual hostility toward psychiatry shown by other departments in medical schools, which my informants attributed to resistance to anything new, to dislike for psychoanalysis, and to a belief that psychiatrists exaggerated the importance of their own role in the doctor-patient relationship. Some thought this hostility was greatest in the London area; Departments of Psychiatry in the universities outside of London seemed to be better accepted,
(v) shortage of psychiatric beds in teaching hospitals. The 12 teaching hospitals in London have a total of only 93 psychiatric beds, with access to an additional total of 204 psychiatric beds, at some distance from the teaching hospitals. Five of the teaching hospitals have no psychiatric beds on the site of the parent hospital.

Fortunately there is evidence that undergraduate psychiatry is improving its position in relationship to other medical subjects. In a report recently released by the Committee on Psychological Medicine of the Royal College of Physicians in London, the members of the Committee freely acknowledged the present shortcomings in psychiatric teaching. The 20 senior teachers who made up the Committee, emphasized the need to produce a medical graduate whose training equips him to deal with psychological problems in practice, and among other suggestions, the Committee recommended that each teaching hospital have at least 80 psychiatric beds. The College of General Practice, too, has recommended that medical schools pay more attention to teaching students on the importance of emotional factors in all disease.

Although the influence of these two groups on the medical school curriculum has not yet produced more hours on psychiatry, it should soon. In future, British medical schools will likely provide more teaching in comprehensive medicine (as McKeown plans to do at Birmingham), and there will be more teaching of psychological medicine by both general practitioners and internists. Certainly, the medical students of the future will receive more supervised in-patient and out-patient experience with psychological disorders. Once each medical school has a Chair in psychiatry, the responsibility of all professors in psychiatry will be both to make psychiatry more scientific, and to collaborate with the heads of other departments in producing doctors with adequate psychiatric skills.

(b) *Post-graduate Education in Psychiatry*

Thanks to the scientific leadership of the staff at the Maudsley Hospital, and to the enthusiasm for teaching and devotion to education of many psychiatric leaders in British mental hospitals, the level of graduate psychiatric training in Britain is of a reasonably high standard. For years Maudsley has provided a two-year graduate course; other university centers are developing similar programs to supplement the in-service training of registrars working in mental hospitals and in clinics. Compared with resident training in North America, the British graduate programs tend to be oriented more towards providing apprentice-like training rather than towards giving a highly organized systemized didactic course.

CHAPTER 17

COMMUNITY SERVICES

1. General Practitioners

Recent changes in psychiatry, as well as in general practice, have increased the importance of psychiatry to the family physician[1] in Britain. Instead of remaining for many years in mental hospital, the psychotic patient now completes his convalescence in the community, and so requires more help from his general practitioner; moreover, because specialists now do most of the surgery (and much of the obstetrics), psychological medicine occupies a higher proportion of the general practitioner's working hours. Not all general practitioners welcome this change, but an increasing number are becoming interested in psychiatry, and are trying to improve their psychiatric skill.

To understand the general practitioner's place in psychiatry, it is necessary to understand his place in the National Health Service. In 1960 there were 20,626 physicians engaged in general practice, compared to 7,292 specialists employed by regional hospital boards. With about 70 per cent of its doctors in general practice, Britain has a higher proportion of family physicians than almost any other country in Europe, and a much higher ratio than Canada (41 per cent), U.S.A. (31 per cent), and U.S.S.R. (lowest at 24 per cent).

In England and Wales, the general practitioner is employed by one of the 138 executive councils; these local committees hire and pay the general practitioners (and also the dentists and pharmacists), but do not interfere in professional matters; the funds, of course, are from the National Exchequer.

All persons covered by the National Health Service, elect to join the panel of one or other general practitioner, and remain in his group until they choose to opt out. A general practitioner is allowed a maximum of 3,500 patients on his panel, but the average is 2,287. Although many consider 1,800 patients to be an ideal number, good work is thought possible with a 2,000 maximum in urban areas and 2,500 in rural districts. General practitioners with more than 2,500 patients claim they are too busy to give proper attention to their patients' social and psychological problems. Doctors usually take more patients than this only because they need the money.

General practitioners receive about a pound per patient per year; since one in four has a part-time salaried job, many family doctors make £ 4,000 or more a year, although most receive between £ 2,500 and £ 3,500. Physicians with less

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[1] Watts, C. A. H., "Mental and Emotional Disorders in General Practice", *The Practitioner*, November 1962, Vol. 189, pp. 641-647.

than 1,500 patients are paid proportionally more per patient; this helps keep panels at a manageable level, and protects the physician in sparsely settled areas.

In the National Health Service Plan, the general practitioner serves in the community as the patient's personal physician, and the specialist looks after the patient once he has been admitted to hospital. Except for those general practitioners who have access to one of Britain's 300 cottage hospitals (25 to 50 beds), no general practitioner can now care for his own patients in hospital, although many, under the direction of a specialist, work in hospital on a sessional basis. Some general practitioners spend one or two afternoons a week in psychiatric units where they examine patients, work in out-patient psychiatric clinics, or even run an electrotherapy service under supervision. At Lancaster Moor, in the Manchester Hospital Region, the Superintendent of the 2,000-bed mental hospital employs several family doctors on a sessional basis. Besides increasing his income, having such an appointment in collaboration with a psychiatrist, enables the general practitioner to improve his psychiatric skill.

For the most part then, the general practitioner works in the community (either by himself or more often in groups of two or three), using his home as surgery or renting quarters elsewhere. In 1946, the Ministry announced a plan to provide the general practitioners with offices in well-equipped community health centers, but so far nothing has come of this scheme. A shortage of funds has postponed the building of these health centers; there has also been effective opposition from some family doctors who feared that subsidized offices would increase their dependence on the Government.

The general practitioner sees about 70 per cent of the patients on his list each year, and sees the ones he attends on an average of five times a year. He usually holds two daily sessions in his surgery (afternoon and evening) and, unlike his North American counterpart, does a good deal of home visiting. Since about 30 per cent of consultations occur in the patient's home, the British general practitioner gets a first-hand look at the social and psychological situation in the family, and is better able to understand and help with psychiatric problems.

British physicians give a variety of answers when asked to state what proportion of their patients come with psychiatric problems; estimates range from 2 to 70 per cent. This discrepancy is due mostly to differences in the criteria used to diagnose mental disorder rather than to a variation in the number of psychiatric patients from one practice to the next. In 1959 a working committee of the College of General Practice agreed that about 30 per cent of the patients seen by the family doctor have psychological illness; 30 per cent is the average estimate of most doctors, yet careful studies by such experienced workers as Watts[1] and Kessel[2] show that only about 11 per cent of those who come to surgery do so *primarily* for psychiatric reasons. At the same time, most other experts agree with Lord Taylor's belief that anxiety or other psychological disturbances complicate physical problems in an additional 10 to 20 per cent of the family doctor's patients.

In his busy Leicestershire practice, Watts diagnoses a new case of senile dementia about four times a year, and sends senile patients to mental hospital

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[1] Watts, C. A. H., and Watts, B. M., *Psychiatry in General Practice,* London: J. and A. Churchill Limited, 1952.

[2] Kessel, W. I. N., "Psychiatric Morbidity in London General Practice", *British Journal of Preventive and Social Medicine,* Vol. 14, 1960, pp. 16-22.

about once every two years. During an average twelve-month period, for each thousand persons on his panel, he sends one to an out-patient psychiatric department, and another for admission to a mental hospital. At least one more mental defective crops up each year, plus one or two new schizophrenic patients; he sees many persons with depression. With only one new alcoholic patient a year, alcoholism is not a serious problem in his practice.

In contrast with a specialist in mental hospital (where most patients are psychotic) the general practitioner sees at least 20 neurotics to one psychotic. The time he spends with each psychiatric patient varies according to the doctor's interest and skill. Even so, the experienced general practitioner can carry out good general practice psychiatry without devoting a disproportionate amount of time to those who are emotionally sick. Even with his unusual interest in psychiatry, Dr. Watts rarely spends more than 20 minutes interviewing a neurotic patient; his knowledge of the patient and of the patient's home circumstances saves him much time.

Most general physicians have a number of mentally disordered patients whom they see regularly either in their surgeries or on domiciliary visits. During a round of house calls, Dr. Watts showed me a chronic schizophrenic, two seniles and a mental defective. Just as they look after chronic cardiac and arthritic patients at home, many family doctors also maintain chronic schizophrenics, seniles, and mental defectives. They do this without fanfare and without too much difficulty, calling on the mental welfare officer for only occasional assistance. In the future, psychiatry is likely to be accepted without question as part of British medical practice; with more psychiatric treatment taking place in the community, the general practitioner will have more of it to do, and will have to know better how to handle psychiatric problems.

In addition to diagnosing and treating psychiatric patients on his own accord, the general practitioner refers some patients for specialist help. In most areas he can refer to one of three centers: (1) to the mental health clinic at the general hospital, (2) to the psychiatric service of the local health authority, and (3) to the mental hospital. The patients whom he thinks need out-patient treatment rather than admission, he usually sends to the mental health clinic. Old prejudices die hard, and general practitioners, like many others, still associate the local health authorities and the mental hospitals with the long defunct Poor Laws, and try to keep patients with more money or with higher social status away from these institutions.

The National Health Service Act of 1946 authorized fees to consultants who, on a general practitioner's request, carried out domiciliary consultation; under this authority many mental hospital psychiatrists now make home visits. Besides being a good service for the patient, and giving the specialist a look at the home, the psychiatrist's domiciliary visit can be a learning experience for the general physician who requested it. Unfortunately, home visiting by specialists is limited by the scarcity of psychiatrists, and because some general physicians remain unconvinced of its advantage.

Except in the hospitals where general practitioners have sessional appointments, or through domiciliary consultations, communication between general practitioners and hospital psychiatrists is not good. General practitioners seldom visit their patients in hospital. Not only are they too busy, but unless they have part-time hospital appointments, they feel out of place in the highly-integrated therapeutic community that dominates most mental hospitals today.

The mental health staff of the local health authority makes more effort to communicate with general practitioners than does the mental hospital staff. Some general practitioners refer more patients to local health authorities than do others (referrals range from none to twenty per doctor each year). All local health authorities employ mental welfare officers, who are interested in the general practitioner's psychiatric referrals (a few local authorities even employ part-time or full-time medical officers of mental health). In dealing with psychiatric problems, the mental health officers provide general practitioners with some social work assistance. Working with the mental welfare officer usually brings the general practitioner in touch with the medical officer of health; this is useful fence-mending for, in the past, these two physician groups have often shown mutual distrust.

In the past, deficient education in psychiatry (both graduate and undergraduate) has handicapped general practitioners in dealing with the problems of the mentally disordered. To fill this gap, some psychiatrists have undertaken to teach family doctors. The best known (and most controversial) course is at the Tavistock Clinic, where a psychoanalyst, Dr. Michael Balint,[1] holds regular seminars with groups of general practitioners. Other psychiatrists have since established similar seminars and refresher courses. Most frequently, it is the younger general practitioner that seeks post-graduate psychiatric education. When the Department of Psychiatry in Edinburgh expected 100 general physicians at a recent refresher course, only 40 came, but for the most part, they were young and quite enthusiastic.

Many uncertainties vex those who want the British general practitioner to practise more and better psychiatry. Will general practice survive in its present form? What factors encourage the family doctor to take a more active part in psychiatric treatment and what impedes this?

Despite pessimistic predictions by the local prophets of doom, general practice seems to have a brighter future in Britain than in most other countries. The proportion of general practitioners has increased to more than 70 per cent of all physicians working in the National Health Service (compared with the United States where general practitioners make up 31 per cent of the physician force). This is despite a number of grievances that the British general practitioner wants corrected. The present pay pattern in Britain favours the specialist over the general practitioner, and certainly the specialist has more prestige. Losing contact with hospitals has made it more difficult for the general physician to keep up-to-date, and influences him to refer many problems to the specialist without trying to find his own solutions first. Critics of the National Health Service claim that, resentful at being blocked out of hospitals and having little chance to specialize when they wish to, many British doctors are emigrating to the United States and to the Commonwealth countries.

On the other side of the coin, the control exercised by the National Health Service will, for the time being at least, keep the percentage of general practitioners high. Furthermore, both the public and the doctors realize that the general practitioner of all physicians is in the best position to provide personal doctor service. Surely being the patient's personal physician brings rich rewards in satisfaction, and eventually will bring more money. So it does seem that general practice in Britain is likely to survive, and even to thrive.

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[1] Balint, Michael, "The Doctor's Responsibility", *Medical World*, June 1960.

What will the general practitioner do about psychiatry? [1,2] Because of the stigma associated with mental illness in the past, the extent of psychiatric disorder in any panel practice has not been generally known. The doctor has entered practice unprepared in psychiatry, and faced with unexpected psychiatric problems, has often become puzzled, anxious and frustrated; this in turn frequently makes him hostile to psychiatry. Moreover, the public attaches high prestige to surgical and medical treatments but does not have the same high regard for those who practise social and psychological medicine. Since mental patients usually require more interviews and more time, and since family physicians receive no extra payment for this extra effort, under the panel system there is little financial inducement to do better general practice psychiatry. Nor does the mental hospital help as much as it should; the mental hospital psychiatrist, bent on creating a tightly organized therapeutic community, does not always make the family doctor feel welcome on the psychiatric ward.

Opposing these influences that steer the family doctor away from psychiatry are even greater forces impelling him to take a more active part in psychiatric treatment. With his former surgical responsibility transferred to other hands, psychiatry now plays a bigger part in what there is left for him to do. Surely the general practitioner's raison d'être is his exclusive opportunity to be his patients' personal physician; no other doctor can support a patient through all his illnesses. A successful personal doctor must be skilled in understanding and meeting his patients' emotional needs. What better preparation for this than becoming competent in the diagnosis and treatment of mental disorder? A good general practitioner must always be a pretty good psychiatrist.

Hospital psychiatrists must pay more attention to general practitioners, and give them more training and support. With chances being that the large mental hospital is on its way out, psychiatric services will likely develop in every general hospital. At the same time, the need to improve consultant—general practitioner liaison should result in more family doctors spending more time in general hospitals. Here, working with psychiatrists in the treatment of some of their patients, general practitioners will become more interested in the emotional problems of all their patients.

But the greatest stimulus towards better general practice psychiatry in Britain today comes from the general practitioners themselves—especially from a bright and vocal group in the College of General Practice. These leaders realize that general practitioners skilled in psychiatry do better by their patients; they also see that general practice will more likely survive and thrive if its members practise good psychological medicine—general practice may well be the salvation of psychiatry and vice versa.

All trends in Britain, therefore, point to more participation by the general physician in psychiatric care. For this he needs more and better education in psychiatry and much closer liaison with psychiatric consultants, and with the local health authority mental welfare officers. In the future more general practitioners will likely treat some mental patients in hospital—either their own patients or others on a sessional basis.

To those concerned about the future of psychiatry, what happens to general practice is of great interest. The inevitable transition of psychiatric care from the asylum to the community should result in the family doctor doing more

[1] *Ibid.*

[2] Franklin, L. M., *Psychiatric Illness in General Practice.*

psychiatry. But in the unhappy event that general practice should disappear, then to fill the gap, specialist psychiatric service would have to extend into the community; thus a new type of general practice (run by psychiatrists) would result, and this would be the worse for everyone.

2. Local Authorities[1]

The Mental Health Act of 1959 firmly established the psychiatric responsibilities of the local health authorities. It clarified the legislation directing these municipal bodies to provide psychiatric services for the mentally disordered in the community. What difficulties face the local authorities in carrying out this directive, and how are they set up to deal with these problems?

The local health authorities administer the local health services of the 62 counties and 84 county boroughs in England and Wales. Traditionally, these 146 local health bodies are required to look after the health of the poor and to prevent illness. Until 1946, the municipalities administered the mental hospitals and the hospitals for mental defectives. When the National Health Service Act of 1946 placed these institutions under the regional hospital boards, the local authorities were asked to care for the mentally disordered in the community (before admission to hospital or after discharge). Until the Mental Health Act in 1959 emphatically reaffirmed their responsibility, and left no escape, most local authorities did little to carry out the 1946 directive. They were short of beds and short of experienced staff, and were often given a chilly reception by the mental health officials, still unhappy over losing control of community mental health care.

But the Ministry made it clear in the Mental Health Act of 1959 that the local health authorities were responsible for the mentally disordered in the community, and had to do something about it at once. By this time, many medical health officers had discovered that mental health problems presented a challenging opportunity, and they were already displaying interest and energy in organizing psychiatric services. Accordingly, mental health was added to such local health services as midwifery, infant care, dental service, health visiting, home nursing and ambulance service. By 1960 the funds paid out for local authority mental health was more than £1,500,000 out of a total of about £25,000,000 paid from the Exchequer to the municipalities for health services; this was half the cost of local authority mental health services, with the other half being raised through local rates.

By the Mental Health Act of 1959, the local health authority must ascertain which mentally handicapped persons in the community needed help, and, where necessary, must provide housing, counselling, guardianship, training and occupation. The municipal educational and welfare services also had responsibilities in the mental health program. Under the authority of the Education Act of 1944, the local education authorities, by 1960, had established 130 child guidance clinics, and collaborated with hospital region boards in setting up 120 more. In these jointly run clinics, the education authority provides the psychologists, and the regional board the psychiatrists. Following a pattern established in 1913, the educational authority continues to ascertain which mental defectives need help, and by 1960 had more than 80,000 on the list—all of whom were outside of hospital.

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[1] Susser, M. W., *Changing Roles and Co-ordination in Mental Health Services,* The Sociological Review Monograph, No. 5.

But to look after mentally disordered people in the community requires skilled staff, and the key man in the local authority is the mental welfare officer. This person had to possess an imposing list of personal qualifications, and had to accept sobering professional responsibilities. He needed to know who in his own area required assistance because of mental disorder. He had to counsel patients and their families, and to direct them elsewhere when other help was needed. To do this, he required much knowledge about mental disorder, and about treatment resources. He had to know and to be able to work along with a variety of persons including not only the patient and his relatives, but also the medical officer of health, visiting nurses, psychiatrists, general practitioners, and employment officers. Finally, he had to do this through persuasion, since the Mental Health Act of 1959 removed his last vestige of statutory authority.

What is the origin of the mental welfare officer, and who are now being recruited to this position? The Lunacy Act of 1890 provided for a relieving officer who was duly authorized to take mental patients to institutions; later he became known as the duly authorized officer. At first he was primarily a peace officer—an escort for disturbed people; at that time he was recruited from mental hospital wards or from law enforcement bodies. But the Mental Treatment Act of 1930 introduced voluntary admission, so the policing duties of the duly authorized officer became less important. When the National Health Service Act of 1946 placed the mental institutions under the regional hospital boards, the duly authorized officer was assigned to the local health authority, where on requests from general practitioners and others, he continued to arrange compulsory admission to mental hospitals. In making doctors responsible for the compulsory admission of mental patients, the Mental Health Act of 1959 removed the last remnant of statutory authority from the mental welfare officer and he became, in effect, a social worker rather than a law enforcement officer.

The Mental Health Act of 1959 made the mental welfare officer responsible to the medical officer of health for mental health services in his municipality. With the nature of his duties being changed from policing to counselling, the mental welfare officer required a different type of training. Besides hiring as mental welfare officers, those of the duly authorized officers interested in social work, the medical officers of health filled their establishments from the ranks of former mental welfare officers of the National Association of Mental Health, and added others with appropriate professional training—including psychologists and social workers. Psychiatric social workers were particularly scarce, and by 1959 there were only 26 of these in the 146 local health authorities. Since at least one mental welfare officer is needed for a population of 25,000, more than 1,500 will be required for the entire country.

The lot of the mental welfare officers has not been easy. Often ill-prepared for dealing with the problems of the mentally disordered, they received limited support and guidance from the psychiatrically inexperienced medical officers of health, and from some of the mental hospital psychiatrists—still smarting over losing control of community psychiatry. Nor were their new relationships always smooth with general practitioners. Formerly the general practitioner could call on the duly authorized officer (now the mental welfare officer) to make all necessary arrangements for admission of his patients to mental hospital; the new Act made the general practitioner do more of this by himself.

Many of the 376 qualified social workers in mental hospitals, and in the mental health clinics of general hospitals, looked askance at mental welfare officers, whom they regarded as unqualified and untrained in social work. The

1951 report of the Mackintosh Committee had recommended an increase in the number of trained psychiatric social workers, but little came of this; the Committee had estimated a need for 700 psychiatric social workers employed in the community services alone—by 1960 there were only 32. The Younghusband Report of 1959[1] recommended increasing to 325 the number of psychiatric social workers employed by local health authorities, and realistically suggested that modified social work training should be made available to mental welfare officers. By 1962, some of these officers had been granted two years training with pay, and short orientation courses were organized for many others. I attended two of these short course sessions—one in Newcastle and the other in Edinburgh. Understandably at both, the mental welfare officers seemed somewhat uncertain, not only about their present role, but also about the future.

The new mental health duties of the local health authorities have been a source of concern as well as satisfaction for the medical officers of health. Most lament their own lack of training for organizing care and treatment of mentally disordered people. The medical officers of health who have accomplished most in the mental health field have done this by making co-operative arrangements with psychiatrists from the local mental hospitals, and from the mental health clinics. One of the best programs is in Edinburgh, where the medical officer of health sits on a planning committee with psychiatrists from the University, and from the mental hospital; together they resolve the difficulties arising during the day-to-day administration of a city mental health program. Several other M.O.H.'s have appointed part-time consultants in psychiatry—a few have full-time consultants.

Some local health authorities give mental health responsibilities to their visiting nurses. To prepare the nurses for this the Health Department in Edinburgh has an in-service program of lectures and mental health instruction for its 100 health visitors—who work closely with the psychiatric social workers from the Royal Edinburgh Mental Hospital.

Besides hiring staff, the local authorities must provide buildings for residential care, training, and occupational placement of its mentally handicapped. Since the days of the Poor Law, the local authorities have housed the helpless and homeless. In 1960, Part III accommodation (residential homes and nursing homes provided under the National Assistance Act 1948) amounted to 84,556 beds, which included 73,881 beds for old persons (with nearly 20,000 of the total being mentally subnormal). Although being homeless was why most of these old people received municipal care, almost all had secondary handicaps such as illness or very old age. Despite being told by the National Health Service Act of 1946 to provide hostels for the mentally disordered, by 1960 only four of the 146 local authorities had constructed special buildings for this purpose. At the Minister's request, however, the local authorities have recently submitted plans for 350 more hostels. It is true that several hospital management committees now maintain hostels and half-way houses of their own; this duplication is understandable during a transfer of a responsibility from one authority to another, and it is not necessarily bad.

Foster home care of the mentally retarded is less well developed in Britain than in many other European countries—especially in Belgium and in Norway.

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[1] *Report of the Working Party on Social Workers in the Local Health Authority and Welfare Services*, London: Her Majesty's Stationery Office.

Some local authority mental health projects are well advanced. The Assistant Medical Officer for Mental Health Services in the City of Edinburgh took me to visit the Willowbrae Day Care Unit for severely subnormal patients (under 12 years of age) where the I.Q.'s range from 20 to 25. A school bus brought the children each day, and there was no cost to the parents for any part of the service—including lunch. This was a good example of a local health authority service helping the parents keep severely retarded defectives at home, without undue strain on anyone by simply providing daytime relief.

Local authorities are now taking their training responsibilities seriously—especially with the subnormal; the shortage of hospital accommodation for subnormals and severely subnormals has increased the need for training centers. These include day centers for:

1. the severely subnormal—those for whom occupation is primarily diversional, and others for habit training,
2. a middle-grade group who can earn small sums in a sheltered workshop, but who have no prospect of holding jobs in the community,
3. a higher-grade group who need training or work in a sheltered workshop. This group includes both those on their way to community jobs, and others temporarily readmitted after failing in the community.

At the present time, 9,804 of 12,387 in the junior group who require training are now being trained, and in the group over 16 years of age, 5,999 of the 12,583 who could take training, are also being trained; training resources still lag behind need. Since many of the mentally disordered in the community are social rejects, local health authorities, with help from voluntary agencies, are setting up social clubs for both the mentally ill and for the subnormal.

When the National Health Service Act of 1946 divided, at the local level, the responsibility for psychiatric care between the mental hospitals, the municipal authorities, and the general practitioners, it did little to improve relationships among the members of this troika. Communications between the mental health staff of the local authorities, and the other two vary from poor in many instances, to fair in some, to excellent in only a few. Communication between local health authorities and mental hospitals is best in places like Nottingham and Oldham, where the chief consultant psychiatrist at the mental hospital is also the medical officer of mental health, and an advisor to the chief medical officer of the local authority. Here the staff of the mental hospitals invite staff from the local authority to participate in conferences and to visit wards. Since this type of co-ordination seems necessary to effective service, perhaps it should have legislative sanction.

Although traditionally hostile to local health authorities, the general practitioner has usually proved a better ally to the mental welfare officer than has the mental hospital psychiatrist. The family doctor often wants help from the mental welfare officer, and often he still calls him when he wishes to admit a patient to mental hospital. Finding mental welfare officers exceptionally helpful, some general practitioners have suggested that all mental welfare officers be made responsible to general practitioners, or at least that both general practitioners and mental welfare officers be located in the same building; most psychiatrists and medical officers of health stoutly resist this suggestion.

Whether they realize it or not, local health authorities, general practitioners, and mental hospital psychiatrists share a common interest in the community care of the mentally disordered. It is hoped that such shining examples

of co-operation as seen in Nottingham, and in some of the peripheral units in the Manchester Hospital Region, may spread throughout England. Only then will true community care be possible, and the prospect of emptying the mental hospitals become a foreseeable goal.

Some who oppose shifting more psychiatric treatment to the community suggest that treating psychotics at home creates an intolerable burden for the family. In their Chichester-Salisbury studies, Sainsbury and Grad[1] have demonstrated that, provided that there is a wise selection of the patients to be treated in the community, and provided that the family receives adequate professional support, the burden can be well tolerated.

A family can look after a psychotic patient best if its general practitioner, a psychiatrist and a local authority visitor, work together on treating the patient, and in helping the family deal with the problems rising during this treatment. These three professionals have a harder time co-ordinating their efforts because administratively the regional hospital board, the executive council, and the local health authorities work as separate units. Of this division, I heard nothing but criticism, yet no one seemed to expect these three groups to be united soon under one administration. Some suggested that the local authority was given mental health responsibility as a sop to compensate it for losing control of the mental hospital. Yet, it does seem reasonable to involve both the general practitioner and the local health authorities in psychiatric care; partly because of the interest and the participation of both in community psychiatry today, the mentally ill in Britain are now doing better than ever before. It was wise to give the local authorities and the family doctors a real stake in the success or failure of psychiatric treatment.

Where can the general practitioner and the health visitors get the training they need for the job? This must come from their contacts with mental hospitals, with mental health clinics, and with psychiatric units of general hospitals. I was told that local health personnel seemed more anxious to be taught psychiatry than most mental hospital staff were to teach them.

To summarize the role of the local health authorities in psychiatry, it must be noted that since the early days of the Poor Law, the municipalities have played a major part in psychiatric care. The National Health Service Act of 1946 took away their control of mental hospitals, but the Mental Health Act of 1959 made the local authorities clearly responsible for looking after the mentally disordered in the community. The local health authorities have access to funds for residential care, and for the training and the re-employment of those who have been mentally ill, and they have mental welfare officers to use as they see fit in running the program.

In its present form, the legislation establishing this program is less than four years old. If the usual British pattern prevails, what is good will be kept and what proves useless will be dropped or ignored; meanwhile, efforts to carry out the present law will result in new ideas which will lead to new projects and, hopefully, to more improvements. Such a pattern of progress requires a capacity for discarding outworn and useless traditions. The British have been accused in the past of retaining traditions that have outlived their usefulness; whether or not this charge is just, it certainly does not apply to British psychiatry.

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[1] Grad, Jacqueline; Sainsbury, Peter, *Evaluating a Community Care Service, Trends in the Mental Health Services* (Freeman and Farndale, Pergamon Press), pp. 303-317.

To what extent would these changes now taking place in British municipalities also work in Canada? Unfortunately, Canadian municipal councils lack the prestige of their British counterparts. In operating health services, Canadian counties and cities encounter the same difficulty in raising local taxes for mental care that used to bedevil the British local authorities. Perhaps also in Canada, the British plan of financing through the National Government, with a pattern of decentralized administration, would be the best way to combine local interest with sufficient funds. Even if methods of organizing community psychiatry in Britain could not be transferred to Canada without change, what is being done in Britain could provide a basis for planning experimental programs which could lead to mental health organizations better suited to Canadian culture.

3. Voluntary Mental Health Associations

Psychiatry in Britain owes a great debt to its voluntary mental health associations. Although, compared to government expenditures on the mentally disordered today, the voluntary associations spend very little, the importance of their contributions is very great. Moreover, it is partly due to their past proddings of governments that the Exchequer today pays out more than £100,000,000 a year for psychiatric care.

The principal voluntary organization in Britain now is the National Association for Mental Health—with headquarters in London. Its impressive list of patrons and board members demonstrates the respect that this organization commands; the roll includes the Duchess of Kent, the Right Honourable R. P. Butler, the Archbishop of Canterbury, three members of Parliament and several prominent physicians.

The Association tries to stimulate progress in the mental health field by sponsoring public and professional education, and by carrying out pilot projects on new services. It was at an NAMH Conference (March 1961) [1] that the Minister of Health announced his plans for emptying half of the mental hospital beds by 1975. At such conferences, professional workers meet with prominent lay persons, and together they strive to increase public understanding and support. The standards, which the NAMH maintains in its public education, appear acceptable to most professionals. The NAMH also sponsors training courses for staff selected to work in the community mental health services. Alone or in partnership with local health authorities or with other professional organizations, it operates some hostels for the mentally retarded and for the mentally ill; at least one of these hostels (at Chiswick) was opened within the past three years. This and other similar units started by NAMH, make up the pilot projects and demonstration programs on which local authorities can build more extensive services.

Although mental health organizations were originally financed entirely by private donations, the NAMH now receives government grants; before the local authorities established their own after-care programs, the NAMH frequently contracted to look after the mentally ill and mentally retarded patients in the community; this required an experienced staff of community workers. With the recent expansion of the mental health programs of the local health authorities, many of these workers have been hired by the local authorities as mental welfare officers; this has brought a most beneficial infusion of trained people into the burgeoning municipal services.

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[1] *Emerging Patterns for the Mental Health Services and the Public*, NAMH, London (Proceedings Conference, 9th and 10th March 1961).

Although it is the largest voluntary organization now aiding the mentally disordered, the NAMH is not the only one. Others include the National Society of Mentally Handicapped Children, Mental Health Research Fund, Mental After Care Association. The League of Friends provides volunteer visitors to many mental hospitals (as do local chapters of the NAMH). Many other organizations contribute to welfare programs for patients, including the Red Cross, the Women's Institute, Boy Scouts and the Legion; in Edinburgh, the Legion insisted that mentally sick veterans who were chronically ill be kept in hostels rather than in the mental hospital—and authority bowed to this pressure.

A review of the past activities of the voluntary groups in the mental health field will explain why, to be useful rather than harmful, the voluntary associations must be well informed. Although even before the Lunatics Act of 1845, public pressure contributed to progress in psychiatric care, none of this pressure was channelled through organizations especially chartered for this purpose. The first such organization (Alleged Lunatics Friends Society—founded in 1845) did more harm than good. During the last half of the 19th century, it fostered the public's fear of wrongful confinement in asylums, and the result was the retrograde Lunacy Act of 1890. In 1876, the Mental After Care Association was established, with Lord Shaftesbury as its first president. Very different from the Alleged Lunatics Friends Society, the Mental After Care Association did much to correct adverse public attitude. By 1898 lay persons interested in the mentally retarded formed the National Association for the Care of the Feeble Minded. This group participated in the public education that resulted in 1913 in separate legislation for the care of the mentally retarded; the same organization sponsored the first training centers for mental defectives.

The Feversham Committee of 1939 reviewed the activities of the Mental After Care Association, and of the Central Association for Mental Welfare (successor to the National Association for the Care of the Feeble Minded) and of two other similar groups. It recommended the amalgamation of the four societies; the last three of these organizations joined forces with the founding of the National Association of Mental Health in 1946.

The voluntary mental health associations deserve great credit for what they have accomplished. Certainly, voluntary associations (along with far-sighted government officials) had much to do with the passing of the Mental Deficiency Acts of 1913 and of 1927, the Mental Treatment Act of 1930, the National Health Service Act of 1946, and the Mental Health Act of 1959. Because of its freedom from government control, and its influence on the voting public, the voluntary association can press for legislative reforms whereas often in the same circumstances a civil servant would be powerless to act.

Provided it has the facts, the voluntary association can provide much useful public education. In a field as laden with emotion as psychiatry the changes now taking place require an enlightened public. Whether due to fear, or to the scarcity of factual information, the public in Britain (as elsewhere) is resistant to the truth about mental disorder. A magazine editor, speaking at a NAMH Conference illustrated this recently; she said that a recent article on mental health in a women's magazine with a national circulation resulted in only 13 letters from readers, whereas a similar article on any other topic of equal importance (childbirth, for example) would have brought thousands of letters.

The public is more resistant (and more confused) about mental illness than about mental subnormality. Although, by and large, professional workers are more interested in problems of mental illness, in Britain as elsewhere, the public

is quicker to give its support in words and money for the care of the mentally subnormal.

Although it is difficult to recruit voluntary workers for mental health projects, once recruited they usually become interested, and stay in the field even at great personal sacrifice. Although not literally a volunteer worker, Lord Shaftesbury demonstrated this devotion with his fifty years of service on behalf of the mentally sick.

Much more volunteer help will be needed in Britain to smooth the transition from the custodial institutions to community care. It is not enough for the mental welfare officers to organize training programs for discharged patients; to keep these patients in homes and in jobs also requires sympathetic assistance from the public. So the voluntary mental health association will always be needed.

4. Out-patient Psychiatric Clinics

Most British general hospitals of more than 100 beds have out-patient psychiatric clinics. The transition in British psychiatry from custody to community care began with the formation of the first of these clinics in 1930; a recent estimate placed the total number of out-patient clinics at more than 700. Its clinics provide Britain with the most extensive psychiatric out-patient service in the Western world. Although most mental health clinics are in general hospitals, many are in mental hospitals, and some in municipal health centers.

Psychiatrists directing clinics located in general hospitals come mostly from nearby mental hospitals, although some clinic directors are from teaching hospitals or from private practice. Most mental hospitals in England and Wales assign one or more consultants (often including the physician superintendent himself) to out-patient duties; some mental hospitals operate clinics in several general hospitals (the Nethern Hospital runs 28 clinics). Each clinic holds from one to six sessions weekly.

During 1959, 144,267 new patients[1] were seen in mental health clinics (compared to 93,145 in 1949 and to practically none in 1929). Including return visits, the total number of consultations varied from three to six times the number of new patients, depending on whether the clinic concentrated on follow-up of discharged patients or on intensive out-patient therapy. In the Manchester area, the clinics treat many as out-patients who elsewhere would be admitted, so their attendance rate has been high. Children make up more than 10 per cent of the new patients in all out-patient services.

In addition to psychiatrists, clinics require psychiatric social workers, psychologists and secretaries; unfortunately, few clinics have a full complement of staff. Since psychiatric social workers are in short supply, many clinics borrow almoners from nearby general hospitals or from the local authorities. Some clinics made use of mental welfare officers from the local authority, although this practice has, on occasion, created problems. At Salford in the Manchester Hospital Region, some qualified social workers objected to the employment of mental welfare officers in mental health clinics; they considered this to be an

[1] Maclay, Walter S., *Trends in the British Mental Health Service* (Freeman and Farndale, Pergamon Press), pp. 3-11.

intrusion of an unqualified person into their field—even though at the time no possibility existed of staffing these services with qualified social workers. Sometimes home visiting is carried out by the psychiatric nurses employed primarily to help with electroconvulsive treatment.

General practitioners refer more than 65 per cent of all the patients seen at the mental health clinics. Although the family doctor tends to refer psychiatric patients who require hospital admission to the local authority mental health service, he usually sends those patients that he wants treated in the community to the out-patient psychiatric clinic in a general hospital. As a result, the patients seen at the mental health clinics have milder disorders, and come from a higher socio-economic group than do referrals to local authority or mental hospital services.

More than 40 per cent of those referred to general hospital clinics have neurotic disorders with anxiety and depression predominating. In most respects, they resemble the patients with neurotic complaints who frequent medical and surgical clinics. It is estimated that 15 per cent of all patients attending medical and surgical clinics suffer principally from functional disorders, yet of this neurotic group only one in ten is referred to a psychiatric service; the remainder receive their supportive treatment from surgeons and internists, and seem to do as well as those referred to psychiatrists.

In addition to neurotics, psychotic patients make up 20 per cent of the referrals to general hospital mental health clinics, with most of the remainder suffering from personality problems or situational disturbances. More than half of the referrals are returned to their family physician after only one visit—only about 10 per cent end up in mental hospital.

It is now clear that not only neurotics, but also psychotics can be examined and treated in general hospital out-patient services. Moreover, as the Manchester program has shown, most if not all psychotics can be treated on a psychiatric service of a general hospital with no referrals to a mental hospital—provided that the general hospital service includes, in addition to in-patient beds, out-patient and day-patient services. The psychiatric service must also have close liaison with community health services, including general practitioners. Whether these services, built around general hospital wards, will make mental hospitals redundant, still remains to be seen.

The treatment resources of most out-patient psychiatric services include the physical therapies, supportive psychotherapy and environmental manipulation. Most clinic psychiatrists prescribe drugs, and many give out-patient electroconvulsive treatment. The psychotherapy tends to be mainly supportive, and in contrast with the 50-minute pattern in North America, 15- to 30-minute treatment interviews (or even shorter) are common. As the part-time clinics are handicapped by a shortage of psychiatric social workers, environmental manipulation is difficult; for this reason many clinics would profit from closer liaison with the mental welfare officers of the local health authority; these could provide more consistent community supervision.

From the beginning of the clinics in 1930, the number of patients seen has increased each year, until two or three years ago; since then clinic attendance has levelled off—especially attendance for treatment. Some hospital management committees report that out-patient demands for service are no longer increasing or have even diminished. Even in the Manchester Region, with its extensive out-patient treatment program, during the past seven years the number of

treatment sessions in the Oldham, Burnley and Blackburn districts have only increased from 13 to 15; this has been despite an increase in diagnostic sessions from 7 to 64. This suggests that the referring doctors are now using the clinics more to help with diagnosis rather than to dispose of difficult problems. Perhaps better communications between hospital psychiatrists and family doctors have started to pay off, so that with what he learns from the specialist during domiciliary visits and clinic referrals, the family doctor has become more interested in psychiatry and more willing to carry out his own treatment.

If there really is a diminishing demand for psychiatric out-patient service, could it mean that the mentally disordered now receive more help from others than from psychiatrists, and if so who are the others? Certainly, besides the general practitioner, mental welfare officers and enlightened lay persons now give more help to the emotionally disturbed.

The changes taking place in British psychiatry are closely related to the changes that brought mental health clinics to British general hospitals. Before 1930, there were practically no out-patient services except at the Maudsley Hospital in London, and at the Radcliffe Hospital (general) in Oxford. Responding to demands to have Britain's psychiatric services under the direction of doctors rather than judges, in 1924 the Government established a Royal Commission on Lunacy and Mental Disorder. In seeking to make psychiatric treatment possible without certification to mental hospital, the Commission studied such programs as the one at Oxford where psychiatrists on the staff of the Littlemore Mental Hospital served as out-patient consultants at the Radcliffe Hospital.

In his 1926 report, Lord Percy, the Chairman of the Royal Commission, recommended that out-patient psychiatric clinics be established in general hospitals throughout the country. Most authorities welcomed this recommendation as a step towards inexpensive psychiatric treatment without the stigma of certification.

Since they employed most of the psychiatrists, the mental hospitals had to supply the directors for these clinics, which they did on a part-time basis. Although the first purpose of the clinics was to make treatment available without certification, soon they began to follow up patients discharged from mental hospitals. This reversed the pattern in the United States and Canada where out-patient services first developed as follow-up clinics, which were later used for treatment.

With the opening of the mental health clinics, the mental hospital staff moved into the community, and, for the first time in history, asylum physicians began to work with doctors in general hospitals. Patients fit to live at home could be treated by doctors experienced in psychiatry; so the wall, which for centuries had isolated the mentally ill, now began to crumble. By 1939, in his report on voluntary services, Lord Feversham was able to say that the clinics were an outstanding success, even though they desperately needed better quarters and more ancillary staff.

Although at first encountering the misgivings that drastic changes usually meet, the mental health clinic program was soon well accepted by the hospitals, by the general practitioners and by the public; it also boosted the morale of psychiatrists working in mental hospitals. The local authorities liked the out-patient services because they were less expensive than hospital beds.

Contrary to experience elsewhere, there is some evidence that out-patient clinics in Britain do keep down, rather than increase, the number of admissions to mental hospitals (this has happened in the Manchester Hospital Region, at any rate).

The clinics have improved public understanding of mental disorder, and have made psychiatry more acceptable to general physicians. Physicians and medical students now see psychiatry less as an oddity, and more as part of medical science. Even so, the acceptance of psychiatry in Britain by other doctors and by the public lags far behind the acceptance of other medical branches, yet the clinics have narrowed the gap, and the day of public acceptance of psychiatric treatment draws nearer.

One must marvel at this characteristically British pattern of progress. Fifty years ago (excepting for some of its mental deficiency programs) Britain, like all other countries, had universally poor psychiatric services. Then a few leaders, like those at Oxford and at the Maudsley Hospital, devised better patterns of treatment service; this led to a demand for better services generally, and then to the Royal Commission of 1924. Within three years, the Commission's recommendations became law. Ten years' experience with this new pattern served as a stepping stone for the next move toward the community; there then followed the familiar cycle of public dissatisfaction, followed by such improved services as at Nottingham and Worthing, a Royal Commission, a new law, and finally another new pattern with the Mental Health Act of 1959.

What is the future for the mental health clinics in general hospitals? As in the Manchester Hospital Region, many will draw closer to the psychiatric services in general hospitals. Besides co-operating closely with general hospitals, the clinic staffs work more closely with the staff of psychiatric services of the local health authorities, and with the general practitioners. At the same time, the clinics seem to be moving farther away from the mental hospitals; perhaps the mental hospital staff will soon follow the clinics into the community.

CHAPTER 18

SPECIAL PROBLEMS

1. Mental Subnormality

The revolution in Britain's health services has improved the care of the mentally retarded. I would like to describe what is being done for the subnormal now, and point out future trends. This culmination of a half century struggle presents a most creditable page in the history of British psychiatry.

Even the nomenclature used to classify mental retardation was changed by the Mental Health Act of 1959. The former terms, "idiot", "imbecile", "feeble-minded" and "mental defective" were replaced by two terms:

(a) severely subnormal, and
(b) subnormal

The category of severely subnormal includes the groups formerly called idiot and imbecile, and encompasses all mental defect below I.Q. 50. Severe subnormality can be defined approximately as "an arrested development of the mind to the extent that the patient will be incapable of leading an independent life or protecting himself from exploitation". Subnormality is similar to severe subnormality, but the disability is much less. Patients in the category of subnormality are described as "those requiring or being susceptible to medical treatment, including training". This group includes those within the I.Q. range of 50-75, formerly called "feeble-minded" in Britain and "moron" in the United States. In this study, unless otherwise indicated, the term subnormal will include the severely subnormal.

Responsibility in Britain for the care and treatment of the subnormal rests either with the regional hospital boards or with the local health authorities—depending on whether the patient is in hospital or in the community; the only exceptions to this are the 1,450 dangerous subnormal patients in institution, which are directly under the Minister of Health. Of a total of 475,409 hospital beds in the 15 regions of England and Wales, 59,521 are occupied by patients who are mentally subnormal. (This compares with about 140,000 mentally ill patients in British mental hospital beds). There are 1.3 beds for subnormals per 1,000 population, compared to .6 beds per 1,000 in Canada. Not only do the British provide twice as many beds per 1,000 population for their mentally retarded as do Canadians, but also in Britain the subnormals occupy a larger percentage of the nation's total psychiatric beds than in any other country. More than 50 per cent of the subnormal patients in hospital are on a voluntary status—in one institution (The Fountain Hospital) 98.5 per cent are voluntary.

The subnormal patients are in 211 separate institutions varying in size from 15 beds to 2,310 (Leavesden in the North West Metropolitan area of London). Half of the patients are in hospitals containing more than 1,000 beds. Actually, the institutions designated for subnormals do not contain all of the hospitalized mental defectives in the country; some subnormal patients are in hospitals for the mentally ill, and there are still many subnormals in psychiatric services in general hospitals as at Oldham in the Manchester Hospital Region, where 52 of its 225 beds contain subnormal patients. Finally, there are the two institutions, referred to above, for subnormals with criminal tendencies. The institutions for the "dangerous" subnormals are Moss Side with 439 patients and Rampton with 1,011—both located in the Midlands.

Some of the hospitals for subnormals are much better than others; the Fountain Hospital has nearly 500 staff (including 5 psychiatrists) for 800 patients. Forty-eight of the hospitals for subnormals have training courses for their nursing staff. After graduating from the three-year course, these nurses are awarded a certificate as Registered Mental Deficiency Nurses. State registered general hospital trained nurses can secure the certificate as Registered Mental Deficiency Nurses, with two extra years training in mental deficiency, and the Registered Mental Nurses get the same certificate with but one extra year's training.

Although the population of the hospitals for the mentally ill are all going down, the number of patients in hospitals for the subnormals is increasing. Between 1954 and 1959, the total number of beds for subnormals increased from 54,561 to 59,521; there are many reasons for this. Although the admission rate is low (4,831 in 1959), the discharge rate is even lower (3,561 in the same year). Only six per cent of subnormals are discharged annually, compared with 60 per cent of the mentally ill; and the total of deaths and discharges does not equal the admissions. Other circumstances increasing pressure for admission include:

(a) an increase in the life span of the mentally retarded; formerly many grossly retarded children died shortly after birth, but now, thanks to antibiotics, most are kept alive. Many who formerly would have died before maturity now live an almost normal span, and as a result, there is great increase in the demand for hospital space for middle-aged subnormals;
(b) with the decline in stigma, parents more readily accept the admission of their retarded children to hospitals for subnormals;
(c) most families move about more now, and since subnormals do not move easily, itinerant families now give up their retarded children.

These three changes explain the current pressure for admission, and the same conditions will continue in the future. If the clamor for more beds for subnormals is to diminish, other ways to meet the needs must be found.

When the National Health Service Act of 1946 removed the responsibility for administering institutions from the local authorities, it clearly made these local health authorities responsible for the care and training of the mentally retarded in the community. Apart from the 59,521 subnormal patients in regional hospitals, the local authorities now have more than 80,000 subnormal patients on their register. The practice of keeping such registers goes back to the period between 1913 and 1959, when the local authority was required both to ascertain the number of mentally retarded patients in its jurisdiction, and also to determine the number of those who needed to be dealt with under the

Act (those requiring training or institutional care). This group on the register includes about 3,000 subnormals for whom the local authorities had been designated as official guardians; patients without responsible relatives needed guardianship.

Each year in England and Wales, the local authorities add a total of about 9,000 new names to the register of subnormals—about 175 new patients per year per 1,000,000 population. If one accepts the conservative estimate of E. O. Lewis that one per cent of the population is subnormal, there would be about 250 subnormal children born each year per 1,000,000 population. If the one per cent estimate is right, this means that the local authorities now succeed in ascertaining about 70 per cent of all defectives. There is a great difference, however, in the number of mentally retarded reported from different counties. Some local authorities report rates as high as 800 per 1,000,000 population, whereas others are as low as 80 per 1,000,000; this discrepancy probably results from a difference in the criteria used, rather than from a real difference in the level of intelligence in different counties. There is little reason to suspect that the rate of subnormality in Britain is less than in North America where three per cent of the population is usually considered to be mentally defective; it is merely just a question of using different criteria.

The local authorities usually assign the main responsibility for developing training facilities for subnormals to their mental welfare officers; some authorities have mental welfare officers who work only with subnormals. Each local authority tries to keep an up-to-date list of all subnormals in the community who need help. In Edinburgh, this list includes 1,361 patients in a population of nearly 500,000; of these, 85 are pre-school and 488 of school age. Training programs are set up for all subnormals excluded from the regular school system, and even for those beyond school age. The level of instruction depends on the age and the degree of retardation of the subnormal person. A retarded child may begin with habit training, and proceed to occupational instruction; then he could go on to industrial training, later to employment in sheltered workshops, and sometimes to a community job. It is estimated that about 10 per cent of the middle-grade subnormals (formerly called imbecile) can be employed in the ordinary labour force.

Of the 145 local health authorities in England and Wales, 102 now have one or more training centers for subnormals under 16 years of age, and 92 have centers for the adult subnormal; these 145 municipalities have a total of 329 full-time training centers, and local authorities have agreed to open at least 350 more. At the present time, there are 19,996 subnormals training in these centers with a waiting list of 5,600 others considered suitable for training, but for whom there is no place at present. Although some consideration is given to the ability of the patient to use ordinary bus transportation, most of the centers do have special buses. Two-thirds of those in the local health authority training centers are of school age; this demonstrates the point so often made that the communities are providing the most extensive training facilities for the school-aged subnormals, and that, as a result, relatives have their most difficult problems with subnormals before they are old enough to go to school, and after the school-age period is past.

The National Health Service Act of 1946 required the local authorities to provide, where needed, living accommodation for subnormals in the community, and the Mental Health Act of 1959 confirmed this. As yet few local authorities in England and Wales have hostels for subnormals, but about 60 have plans to

build such hostels soon. Since most subnormals still in the community live at home, there is no agreement on the purpose of these hostels. It has been suggested that ultimately they should replace the large hospitals, so that those formerly in large isolated institutions will, in future, be kept nearer to their relatives; some local authorities plan to use these hostels for boarding subnormal children from rural areas, who could then attend the county borough day-training centers.

Although there are 145,000 subnormal persons on the register (regional and local authority), there are undoubtedly thousands in the community as yet unascertained—many of whom surely need help. If one accepts the conservative estimate that one per cent of the population is subnormal, this would mean a total of 500,000 subnormal persons in Britain, more than 350,000 of whom are as yet unregistered. For planning services, it is convenient to divide this group into three sub-groups that might be roughly classed as:

(a) those under I.Q. 20,
(b) I.Q. 20 to 50,
(c) those over I.Q. 50.

Assuming that Britain has 500,000 subnormals, it is estimated that 25,000 would be in the lowest of the three groups, with 100,000 in the middle group, and 375,000 in the higher. Of the 125,000 in the lowest two groups, about 35,000 are now in British institutions. This includes about 10,000 who are in the lowest group, and 25,000 in the middle bracket. This means that there still remain in the community about 15,000 who are severely retarded, and 100,000 who fall into the imbecile class; these severely tax the community's resources.

In an attempt to determine the needs of the subnormals, and of their parents, Tizard and his colleagues[1] have studied many of the families of defectives. In this survey, they compared the attitudes of parents whose children were placed in institutions with those of parents who have kept their subnormal children at home.

Tizard found that families who kept their severely retarded children at home had suffered socially and financially compared with those who had sent their subnormal children to institution. Of those with severely subnormal patients in the home, a third reported no problems, about a third had some problems, and a third had severe problems. Thus a total of 40,000 families were having great difficulty coping with a mentally retarded person. Yet, only a third of those with difficulties agreed that they would consider giving up the subnormal member, even though some realized that institutional care would become necessary later on. Most of these families complained somewhat bitterly that no one, at any time, assisted them with advice and financial help in caring for their retarded child at home.

Tizard was told by the families representative of the approximately 35,000 severely subnormal in institution, that few expected the retarded child to live at home again, yet at least one-third of the parents declared they would have kept the subnormal child if they had had adequate advice and financial help at the time he was placed in institution. From this it appears, that whereas placing subnormal children in institutions results in the family being better off financially and socially, yet many regret having been (in their view) forced to

[1] Tizard, J., *Public Health Aspects of Severe Mental Subnormality*, presented to the Royal Society, April 1960.

give up their child. Both those who gave up the child, and those who have kept their child, believe that their situation would have been much better if they had received professional advice and financial support at the proper time. Most studies suggest that patients who are kept at home do better than those who go to large institutions; their habits are better and they seem happier.

The story of changing patterns of caring for the mentally retarded in Britain explains the interest shown in the subnormal today. Before the Napoleonic Wars, there were no special facilities for the mentally retarded. Most of the idiots and imbeciles then requiring care were kept in workhouses or in Poor Law Infirmaries, and most of the troublesome morons went to jail—some even to the gallows for petty theft. After the 1808 advent of county asylums, the severely subnormal were placed either in these asylums or in the workhouses. During the first half of the nineteenth century, a few persons displayed sporadic interest in mental deficiency as a disorder distinct from mental illness, and a few small private homes for feeble-minded were opened.

As the public's opinion of the asylums deteriorated, during the second half of the nineteenth century, the friends and relatives of the mentally retarded began to demand that the mental defectives be separated from the insane. As a result, the Idiots Act of 1888 was passed; it permitted counties and county boroughs to build separate quarters for the retarded, and authorized grants from the consolidated fund to assist in operating these units. Although the Lunacy Act of 1890 failed to acknowledge the difference between mental deficiency and mental illness, the Elementary Education (Defective and Epileptic Children) Act of 1899 empowered the local educational authorities to set up special schools for the education of mental defectives.

The passing of legislation in favour of the subnormal results from the strenuous efforts of their friends, for unlike the mentally ill, the retarded have always had a powerful lobby to support them. In the struggle to improve the lot of the subnormal, the friends and relatives of this group have, during the past 100 years, set up voluntary organizations which, to say the least, have struggled vigorously on behalf of the mentally dull.

The pressure to separate the retarded from the mentally ill increased during the first part of the twentieth century. Those demanding separate hospital facilities for the protection of the retarded were joined by a group wanting the same thing for quite different reasons—the people who wanted institutions built for the protection of the community from the mentally retarded. Resulting in part from such questionable studies as reported in the stories of the Jukes and Kallikaks, but based mostly on unreasonable prejudice, many persons believed that much crime and poverty could be attributed to mental defectives. They also thought that mental deficiency was an hereditary disease preventable only by preventing procreation through segregation of defectives during their reproductive years. Those seeking to segregate the mentally retarded cited the writings of Darwin and Galton, and warned that without prompt action, that civilization could be overrun by swarming imbeciles—the blemished "Fruit of the Family Tree".

Pressure both from the friends and from those who feared the mentally retarded resulted in the Royal Commission on the Care of the Feeble-Minded (1904 to 1908). The report of this Commission was partly incorporated into the

Mental Deficiency Act of 1913. This Act divided the mental defectives into four categories:

(a) idiot;
(b) imbecile;
(c) feeble-minded, and
(d) moral defective.

It set up a control body amalgamated with the Lunacy Commission to form the Board of Control. The Act required the local authorities to establish committees on mental deficiency, which would plan services at the county level. Each local authority had to ascertain all of the mental defectives within its jurisdiction, and determine those who were "subject to be dealt with". (Being "dealt with" meant being placed:

(a) in an institution;
(b) under guardianship, or
(c) under statutory supervision—including training).

The permissive legislation of the Idiots Act of 1888 had resulted in 38 institutions by 1914. Under the terms of the 1913 Act, all local authorities were now required to build county institutions for the segregation and care of mental defectives; their Mental Deficiency Committees were directed to promote the training of those defectives under statutory supervision. Many of the local education authorities established special classes for morons, and with prodding and some help from the voluntary associations, some local health authorities set up training centers for the lower-grade defectives. The Act also authorized the building of the Moss Side and Rampton institutions—for mental defectives with dangerous tendencies.

In retrospect, the chief criticism of the Act of 1913 was its emphasis on the segregation of mental defectives from the rest of the community; this led not only to the building of many large institutions, but by increasing prejudice against the retarded made it difficult for many of the retarded to return to society. On the other hand, the Act encouraged the working out of new techniques for assessing and training dull people.

After World War I, the voluntary societies continued to push the local authorities to do more for the mental defectives. The Mental Deficiency Act of 1927 did little more than restate and confirm the Act of 1913, but it created so much interest that the Wood Committee of 1929 was set up. The report of this Committee recommended more vigorous use of community services (including half-way houses), more use of guardianship, and more assistance for those defectives under statutory supervision. The report published results of a celebrated survey by Dr. E. O. Lewis. Lewis concluded that mental defectives make up one per cent of the population with the group comprised of idiots—5 per cent, imbeciles—20 per cent, and feeble-minded—75 per cent. Lewis' estimates have been considered reasonably accurate, and the three categories that he defined are still made use of today—even though the titles have become obsolete. Lewis' classification of patients according to social performance has been appropriately criticized on the grounds that achievement may be impaired by many problems other than mental deficiency.

The belief of some eugenists that defectives should be sterilized, culminated in the Brook Report of 1934, which recommended passing laws authorizing sterilization; opposition to sterilization soon killed this recommendation, and the Brook Report has not been heard from since.

The National Health Service Act of 1946 made the Regional Hospital Boards responsible for almost all institutions for the mentally retarded, and made the local health authority responsible for the care and training of those mental defectives still in the community. During the next 13 years, local health authorities maintained those training programs already established, but did little to start new ones. The Mental Health Act of 1959 clearly emphasized the responsibility of the local health authority to provide adequate facilities for the training of subnormals in the community. This gave rise to a burst of interest, resulting in new training programs, with much more being planned for the subnormal at the local authority level.

Besides recasting the definitions and classification of mental deficiency, the Mental Health Act of 1959 dealt with the training problems of the aggressive high-grade subnormal patient—including safeguards against unjustified compulsory detention. Under the Act, unlike the mentally ill and the severely subnormal, the high-grade subnormal patients cannot be admitted unwillingly for treatment unless under 21 years and even then must be discharged before reaching age 25 (unless considered dangerous).

What questions stand out, when one looks for future trends in the care of the mentally subnormal in Britain? The major uncertainty concerns the future role of the large institutions, which now house almost half of Britain's known mental defectives. Although called hospitals, they are more like hostels. Although many do have good diagnostic facilities, yet better diagnostic facilities could be set up in general hospitals where, in addition to psychiatrists, there would be paediatricians and neurologists; besides evaluating social performance, those who diagnose mental deficiency today must know something of neurology, biochemistry and genetics.

Except for the antisocial group, the large institution has little to offer to the higher grades of subnormals that could not be provided better elsewhere. The British argue about who should look after the antisocial mental defective and where. Some psychiatrists now treat psychopathic subnormals in permissively run small units; others use industrial therapy extensively. How to treat the subnormal who misbehaves is one of psychiatry's most difficult questions, and the answers are not yet available.

Most families of the mentally retarded dislike the large institutions. Most have some desire to keep the retarded child at home and so demand more assistance from the local health authorities.

Obviously institutions now containing a total of 60,000 patients, and still with large waiting lists, will not be quickly replaced by other types of care. However, such highly regarded researchers as Tizard have recommended bold pilot projects involving new types of service. In future, local diagnostic clinics are likely to expand, and to co-operate more closely with others in the community who can help the family of the subnormal. Once they know more about mental retardation, family physicians will assume a larger role in diagnosis and in counselling. More mental welfare officers trained to work with retardation will be required; they will counsel the parents of the subnormals, and help the older retarded find work and living accommodation. Many local authorities have established crèches for the day care of small children who are severely subnormal. Some of these crèches have added a few beds in which severely subnormal children can be kept for short periods so that the family may be temporarily relieved of their burden.

Many higher-grade subnormals now attend special classes in the regular schools; some authorities believe that these children will stand a better chance ultimately of being absorbed into the working force if they receive their education in the regular classes with due allowances made for their slower pace. Obviously, such a change would be approached carefully.

Some municipalities have introduced a plan for the training of the middle-grade retarded patient (the highest level of the severely subnormal) that they hope will make caring for this group easier. Starting as a small child in the training center of the local health authority, the severely subnormal person will proceed to adult training, where he will be taught to earn money under sheltered conditions; an increasing number of this group will be discharged under supervision to the community's work force. These patients will require more hostels than are now available; when the middle-aged subnormal loses the relatives who have been supporting him, he will live in these hostels rather than in institutions for the subnormal, or in chronic hospitals for the mentally ill.

British psychiatrists still debate whether severely subnormal patients should be admitted to the large institutions, or cared for in small annexes close to their homes and close to the local general hospital. Many authorities prefer the annexes, yet in the National Health Service's Hospital Plan for England and Wales (1962), many regional boards have projected new 400- and 500-bed institutions; these would meet the increasing pressure for institutional care, but leave many problems still unsolved. Such contradictions between theory and performance become understandable in the need to do something quickly about the problem; they must be viewed with tolerance.

In summary: the trends are towards improved local services with the family physician better oriented, so that he can help the parents of subnormal children deal with their day-to-day problems. Prospective changes include more flexible programs in the regular schools, with more training centers for the young severely subnormal patient, and much more industrial training and employment for subnormal adults. There are less definite trends towards providing small residential units for the lower grades of the severely subnormal—many authorities still favor improving the large custodial institutions.

Although much has been learned about the genetics and biochemistry of mental deficiency, as yet researchers have scarcely scratched the surface in these studies. In social research in subnormality, Tizard and his colleagues have published excellent reports and the number of such studies is increasing. Since current psychometric tests vary as much as 12 points in 8 per cent of the patients tested, there is a definite need for more research on diagnostic methods; yet depending on social competence to determine the degree of mental deficiency is not good enough. So, a wide variety of questions about mental retardation are now being examined by researchers and administrators.

2. Psychiatric Services for Children

British psychiatric services for children present a study in contrasts; no other branch of psychiatry shows less uniformity or more divergent views. The psychiatric services for retarded children are good, and the programs for diagnosing and training the subnormal children rate among the world's best. Child guidance services in schools also tend to be good. On the other side of the

coin, Britain has inadequate hospital accommodation for mentally ill children. Of all the beds for the mentally ill, only 10 out of each 3,000 are suitable for persons under 16 years of age.

England and Wales have more than 350 psychiatric clinics for children. These include 120 child guidance centers (mostly located in schools), operated by the local education authorities, and 100 centers exclusively under health authorities—with the remainder jointly operated by both of these groups. The health authorities have set up most of their clinics in general hospitals, usually near paediatric departments. By and large, the children treated in hospitals are sicker than those seen in school clinics. Whereas psychologists usually run the school clinics, psychiatrists direct most of the health authority clinics. Frequently, regional hospital boards and nearby local health authorities jointly operate clinics.

Most of the child guidance clinics follow the traditional staff pattern, employing psychiatrist, social worker and psychologist; educational psychologists dominate the child guidance centers run by the educational authorities—even where the nearby mental hospital sends a child psychiatrist to join the team; psychiatrists usually direct the clinics located in general hospitals. Since psychiatric social workers are so scarce, some clinics, despite opposition from professional associations, have used mental welfare officers in social service investigation and in follow-up.

The increase in the number of new patients from 3,149 in 1949 to 16,735 in 1957, demonstrates how much the clinics have expanded in a ten-year period. That the in-patient psychiatric services have not done as well, was shown by a survey in 1955, that found only 311 hospital beds (in 11 units) set aside for children with psychiatric problems. Since, at that time, only 12 more units were being planned, it is likely that now there can be no more than 20 children's units altogether—with a total of less than 500 beds. Half of these units are administered by mental hospitals, with the others by children's hospitals and general hospitals; most are located in the south of England.

Britain is seriously deficient in the number of child psychiatrists, although the child psychiatry section of the Royal Medico-Psychological Association contains more than 400 of the total of more than 2,000 members of that organization (less than 200 of these are engaged full time in child psychiatry). Many of the consultants working in child guidance services have other responsibilities besides treating children, and their training and experience vary a great deal. Britain still has limited resources for training child psychiatrists. The number of good training posts does not exceed 20—whereas at least three times as many would be required to meet the demands for current child services, and for anticipated expansion.

The history of child psychiatry in England helps explain the present complex situation. In 1939, the Feversham Report recommended two types of child psychiatric clinics—one to deal with problems arising in the school, and another type to handle psychiatric problems in children's hospitals. The Education Act of 1944 provided authority for child guidance centers in schools and so the school clinics were first off the mark. But in 1946 the National Health Service Act made it clear that all treatment services should come under regional hospital boards, and during the past few years, regional hospital boards have opened several child psychiatric clinics. The division of responsibility between

the school clinics and the hospital clinics has created much confusion—recently compounded by the new-found enthusiasm that the local authorities now feel towards mental health. Not long ago, a statement from the child psychiatry section of the Royal Medico-Psychological Association has emphasized that mental disorder in children should be considered a medical problem, and that in future all treatment services should be set up in hospitals. Support for this view has come from the National Association for Mental Health, and from a number of committees created to clarify policy on child mental health. Although personally I encountered no doctor opposing the view that mentally disordered children should be treated by medical rather than educational authorities, yet, I thought I could sense more anxiety and uncertainty about the child psychiatric services than about any other psychiatric program in Britain; the final answers are not in yet.

Perhaps some comments from two of Britain's most respected child psychiatrists would make the picture clearer. Dr. W. Warren of the Maudsley Hospital makes a strong case for child psychiatry to continue as part of general psychiatry, with the child psychiatrist having close contacts with paediatricians and educational psychologists. He believes that children's hospitals should have wards for both acutely and chronically disturbed children, and that these should be under child psychiatry, and that paediatricians supported by child psychiatrists should treat the less disturbed children in the standard paediatric wards. He would use separate wards to treat those brain-damaged children who require long-term therapy.

One of Scotland's leading child psychiatrists, Dr. Margaret Methven, eloquently presents the views of many child psychiatrists. She suggests two main causes for the psychiatric problems of children: (1) bad home conditions, and (2) genetic factors. According to Dr. Methven, child psychiatrists must base their treatment on an understanding of the home situation and devise methods to help the child and parents at the same time. She would assign the major responsibility for treatment facilities to the regional hospital boards rather than to the schools, and would have the treatment beds in the paediatric area, but not have the disturbed child located too close to other children. To Dr. Methven, treatment means support for the parents, and play therapy for the children; she does not use drugs extensively. She believes that the general practitioners must diagnose and treat many children with psychiatric problems; to Dr. Methven, the future of child psychiatric treatment lies with the medical profession.

Britain does have a small but vigorous group of child psychiatrists, trying to create better conditions for the treatment of disturbed children. Among themselves, these child psychiatrists agree reasonably well on the nature of the problems, and on the facilities needed. They consider that child psychiatry affords the greatest hope for preventive psychiatry, yet at the same time they give top priority to the treatment of mentally sick children. By and large they approach psychiatric problems in children from a social rather than a physiological (or even a psychodynamic) viewpoint.

For the most part these planners want wards in which trained staff can deal with parents and children when the problems are acute, as well as some wards for children who will remain disturbed for a long time. General practitioners must be able to recognize psychiatric problems—in some instances counselling parents themselves, and at other times refer the problem to the proper services.

The experts recommend that England and Wales need nearly 300 qualified child psychiatrists, and believe that it would require at least 70 training posts to maintain so many established positions.

Child psychiatrists disagree somewhat in their views about the 130 well-established child guidance centers in the educational system; most believe that these should continue, but not treat severely disturbed children. They want a total of 200 children's psychiatric clinics established under regional hospital boards, with these working closely with the same number of in-patient units. This would increase the number of beds for the treatment of psychiatric problems in children (not including subnormality) from 10 beds per million to 80 beds per million; the beds would be placed under the control of child psychiatrists in paediatric complexes of general hospitals.

Besides the 4,000 acute beds needed for disturbed children, child psychiatrists want at least 10 beds per million located in chronic treatment annexes for long-stay problems; these would be near, but not in, the acute psychiatric service. Many British psychiatrists would place adolescent services under the control of child psychiatrists, and have the adolescent units near or in the adult psychiatric services of the general hospital. They would also have therapeutic hostels set up for children and adolescents who could attend the regular schools or work programs (even if unable to live at home).

To sum up: a survey of trends in child psychiatry in Britain reveals hazier outlines than in other branches of psychiatry; the needs are clear enough, but there is less agreement on how to meet them. Regional hospital boards plan new treatment units for disturbed children, yet much research and experience will be needed before the future pattern of child psychiatry in Britain becomes apparent.

3. Psychopathic Disorders

Psychiatrists in England and Wales disagree vigorously on what should be done about treating psychopaths; since psychopaths are always difficult, often dangerous, and seldom respond well to treatment, this disagreement is understandable. Difficulty in defining psychopathy, as well as difficulty in separating it from other types of aberrant behaviour, makes these disagreements sharper. Because many lay people equate psychopathy with crime, the psychopath arouses hostility among the uninitiated, and even among the professionally experienced; so the picture is muddled indeed.

The Mental Health Act of 1959 defined psychopathic disorder as "a persistent disorder of personality (whether or not accompanied by subnormality), which results in abnormally aggressive or seriously irresponsible conduct and requires or is susceptible to treatment". A typical example of psychopathic conduct occurs in the youth whose antisocial behaviour includes quarrelsomeness, sex difficulties, histrionic suicidal attempts, addiction to drugs and even a fondness for dangerous weapons.

Psychopathic disorder is not a clear-cut entity, because it includes patients also having symptoms of other related disorders. It includes many of the 20,000 prisoners in British jails, and many of the 1,500 subnormals at the Rampton and Moss Side Institutions (subnormals who are considered dangerous). Psychopaths also shade into the group of 900 patients at the Broadmoor Institution

which was founded in 1864, and which now houses mentally ill persons who have committed offences. Some of the Broadmoor patients were transferred there from the penal institutions because of mental illness, others were committed to Broadmoor to await Her Majesty's pleasure, having been found "Guilty but Insane". When the Moss Side and Rampton Institutions were set up after World War I, they were first administered by the Board of Control and later transferred to the Ministry of Health; originally administered by the Home Office, Broadmoor was transferred to the Ministry of Health by the Criminal Justice Act of 1948.

Since 1839 when Prichard first claimed in Bristol that antisocial behaviour could result from mental disorder (apart from mental illness or subnormality), the psychopath has been an object of discussion and disagreement among psychiatrists and penologists. Between 1954 and 1957, the Royal Commission on Law Relating to Mental Illness and Mental Deficiency tried to clarify thinking about psychopaths and to reform the laws.

The Mental Health Act of 1959 authorized admission of psychopaths to mental hospitals; like the mentally ill and the severely subnormal, psychopaths could be admitted for treatment on the recommendation of two physicians (one a psychiatrist)—but with some special limitations. Physicians could arrange compulsory admission for the psychopath only if the psychopath was less than 21 years of age; moreover, unless considered dangerous, he had to be freed before the age of 25.

The provisions of the Mental Health Act of 1959 encouraged courts to watch for psychopathic disorder in offenders; judges could choose whether to send such persons to prison or the mental hospital. Mental hospital admission from courts required the further recommendation of two physicians, with the superintendent of the mental hospital expressing his willingness to receive the patient. Since many psychopaths would continue to be dangerous to the public, regardless of psychiatric treatment, the judge could, if he chose, make a special order restricting the mental hospital superintendent in discharging the patient.

The sections of the Mental Health Act of 1959 dealing with psychopaths have led to much discussion and disagreement.[1] Many superintendents believe the mental hospitals (and psychiatric units in general hospitals) are not suited to the treatment of unwilling psychopaths. These patients are troublesome, and upsetting to other patients and staff, and since they often leave without permission, they bring hospitals into disrepute. Superintendents have difficulty fitting the psychopath into the regime of hospitals with open door programs. Moreover, many psychiatrists have little faith in the efficacy of present day methods of treating psychopaths.

But many psychiatrists (not always those with direct responsibility for patients) encourage the admission of the psychopathic patient to mental hospitals, pointing out that these patients suffer from mental disorder, and that the prisons lack both the trained staff and the therapeutic attitudes needed for helping mentally disturbed persons. They support this view by pointing to two or three treatment programs in which psychotherapy of psychopaths has reportedly produced good results. One of these is at the Dr. van der Hoevenklinek at Utrecht; it was established by Professor Baan, but when I visited in

[1] "Security Provisions in the Mental Health Service", Annual Conference of BMA, Psychological Medicine Group, *British Medical Journal*, February 17, 1962.

April 1962, it was under the direction of Dr. A. N. Roosenburg. Those who would treat psychopaths in mental hospitals also point to the work of Dr. Maxwell Jones at the Belmont Hospital, where he treated many psychopaths in the permissive atmosphere of a psychotherapeutic community.

It would be presumptuous for a Canadian to conjecture how the British will resolve their differences about the psychopath. Yet I believe that the trend toward open hospitals, and toward expanding psychiatric services in general hospitals, will ultimately preclude the involuntary admission of psychopaths to the community's psychiatric treatment units. Nor does it seem likely that many psychiatric departments will establish special locked wards just for the psychopaths—thus violating the principle of the open door, and adversely affecting other patients. If the regional hospital boards continue to be responsible for the treatment of some patients with psychopathic disorder, they will likely set up separate units—one or two to a region. Psychiatrists would then administer the treatment program and maintain security precautions; such units could carry out useful research on psychopathy.

Perhaps the best program of understanding and treating psychopaths could result from establishing psychiatric services within the prison set-up. With this in mind, a new prison is being opened at Grendon, Underwood in Buckinghamshire;[1] this will house 350 prisoners transferred from other prisons, because they needed psychiatric treatment. The introduction of such programs into penology, together with good research, should improve correctional treatment and possibly provide leads in the prevention of crime. Unfortunately, under existing laws, only those psychopaths found guilty of committing crimes could benefit directly from these psychiatric services in prison; perhaps the law should be changed.

4. Mental Disorders of the Aged

Of all mentally sick people in England and Wales, the confused old person has the best chance of being treated with the physically ill. More than 100 British general hospitals now have geriatric units, and a large percentage of the patients in these units have mental symptoms. Besides being mentally sick, more than half of confused old people also have organic disorders (sometimes the cause of the mental illness). In many centers psychiatrists work closely with geriatricians, and in those units, mentally ill old people are less segregated than are other psychotics, and less often sent off to a mental hospital to stay until they die.

Some of the changes made recently in the treatment of mentally sick old people in Britain could greatly change the treatment of the mentally sick of all ages. Mental disorder is one of the most difficult problems in geriatrics, and psychosis of the aged is the most discouraging illness in psychiatry.

Until 200 years ago, Britain's confused old people were looked after at home; in those days people died at an earlier age, and so there were fewer psychotic old than now. During the eighteenth century, old people with mental disorder were placed in almshouses with other chronic sick. Tuke's successful efforts at the end of the eighteenth century to improve mental care led to the building of mental

[1] Snell, H. K., "H.M. Prison Grendon", *British Medical Journal*, Sept. 22, 1962.

asylums, and some of the mentally disturbed old entered these institutions. Thus, during the nineteenth century the aged mentally disordered who could not be kept at home went either to workhouses or to these asylums.

Because of their growing reluctance to designate some citizens as paupers, municipalities, during the twentieth century, took over the Poor Law Infirmaries, and tried to make these into decent chronic hospitals. Since more than half of the inmates of these institutions were mentally ill (as well as having chronic physical illness), the mentally ill old people benefited by this change.

Then, in 1948 the National Health Service took over all hospitals, including the chronic hospitals; in the reorganization of hospital services, many of these county and county borough institutions became comprehensive hospitals with acute as well as chronic services. This led to better medical care with the mentally ill again profiting along with the rest.

Immediately after World War II, a London physician, Dr. Marjorie Warren, demonstrated that many geriatric disorders were reversible, and she showed how, with active physical and social rehabilitation, confused old folks, expected to stay in hospital indefinitely, could often be returned to a useful life in the community. So, many physicians became interested in geriatrics. After Dr. Warren's untimely death, Dr. Lionel Cosin of Cowley Road, Oxford, vigorously applied her techniques in his 200-bed geriatric service. Here Cosin has shown that, with an active therapeutic program and with good community facilities, nearly half of all chronically sick old people admitted to hospital can be returned to the community.

Soon other internists began working with old people, and so by 1962, more than 100 geriatric centers had been established in British hospitals, with many more planned. Most of these geriatric units are in the former council hospitals (referred to above), which are now part of the National Health Service. In Dundee, Dr. Taylor-Brown showed me a most attractive unit, in which he treats sick old people. Like many other geriatricians, he runs a program graded according to the patient's condition; as he improves, the patient's activities are gradually increased until he is fit for discharge. Visitors marvel at the work and money put into his geriatric program.

Although nearly half of the patients in the geriatric services of general hospitals have mental symptoms (some are quite psychotic), many geriatricians still hesitate to admit patients whose chief problem is mental illness. Yet Cosin believes that he can and should admit all psychotic old persons in his area requiring hospital care. Of those he admits, more than 10 per cent are too psychotic to ever be returned home; he transfers these patients to a 52-bed unit called Longworth, located about 10 miles from Oxford. I thought it strange to place these very sick people so far from an acute hospital service. Many geriatricians transfer patients who are severely depressed and disturbed to psychiatric services, while retaining the patients whose mental symptoms do not upset the geriatric unit.

Britain has 59,459 beds (1.3 per 1,000 population) set aside in hospitals (other than mental hospitals) for geriatric patients; it is estimated that more than 45 per cent of these patients have mental symptoms. Nearly half of all the patients admitted to the better-run geriatric services are able to return home after treatment; this includes many who were primarily confused. Of the

remainder, most die within three or four months of admission. In the geriatric units, two types of patients stay a long time: (1) a group with severe physical handicap and (2) a group (about 10 per cent of the total admissions) with severe chronic mental symptoms; there are, of course, many with both physical and mental disabilities. British psychiatrists are trying to decide whether it is best to transfer these patients to mental hospital, or to care for them in long-stay annexes adjacent to a geriatric service; most now go to mental hospitals, but support is growing for using long-stay annexes near general hospitals.

To the thousands of confused old people now being treated in geriatric services of general hospitals must be added other thousands of old psychotics that have accumulated in England's mental hospitals. At least 40,000 of Britain's 140,000 mental hospital patients are over 65 years of age, with more than half suffering from chronic functional psychoses—mostly schizophrenics who have grown old in hospital.

During the past 15 years, many mental hospitals have improved their geriatric services a great deal. In Nottingham, the Mapperley Hospital[1] now operates a 200-bed geriatric unit (St. Francis) in what was formerly a municipal institution. Because of requests for assistance from general physicians, Dr. Duncan Macmillan, the Medical Superintendent at Mapperley, has developed a community geriatric service. He sees mentally ill old people at home, and helps plan their care.[2] Some of these old patients continue under the care of their own family doctor—often assisted by the local mental welfare officer; other senile patients attend a privately endowed day hospital service at a unit called Nuffield House. A few are admitted to the main unit of the Mapperley Hospital, but most of those needing admission go to the acute service at St. Francis (geriatric hospital); 50 of St. Francis' 200 beds are set aside for this acute service. Dr. Macmillan sets the stage for rehabilitation when the patient is admitted, by telling the relatives that he will likely be home within four weeks.

This city of 400,000 has 150 beds at St. Francis hospital for long-stay geriatric patients, because even with the best organized community service, a number of old people are so mentally sick (and often physically sick as well) that for an indefinite period they will need skilled medical and nursing care. How adequate is Nottingham's provision of .4 beds per 1,000? Evidence suggests that it is enough as long as the community services are good.

Britain has 170,000 old people in its institutions (3.5 per 1,000 of its aged population). These include 40,000 in mental hospitals, 60,000 in geriatric centers, and more than 70,000 in Part III (National Assistance Act) accommodation—operated by the local authorities. Well over half of this group suffers from mental disorder—varying from minor confusion to incapacitating dementia. Outside of the institutions, there are also many old persons with severe mental handicaps. In a survey in Newcastle, Roth[3] discovered that 30 per cent of all persons over 65 living at home showed some mental symptoms, and that a third of these were psychotic. Projected to the total population, this shows that nearly 500,000 old people in British communities have some psychotic symptoms. Organic conditions (mostly senile dementia and cerebral arteriosclerosis)

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[1] Macmillan, Duncan, "Mental Health Services for the Aged", Supplement, *Canada's Mental Health* (June 1962).

[2] Macmillan, Duncan, "Preventive Geriatrics", *The Lancet*, December 31, 1960, pp. 1439-1441.

[3] Report of the Medical Research Council for the Year 1960-1961, Her Majesty's Stationery Office, 1962.

account for about half of this group, with depression the second most frequent disorder.

It is true that most of these psychotic old people do not need hospital care, but improved community services would make it easier to look after them elsewhere. The law requires local authorities to be responsible for the care of handicapped people in the community. How good is the accommodation provided at the present time? Not yet good enough for those chronic mentally ill without homes who could be cared for in hostels; few hostels have been built. Should future Part III hostel accommodation admit all sorts of old people, including those with mild mental symptoms? Probably yes, because it would be impossible to ever completely separate the physically ill, the mentally handicapped and those who are just poor.

Should confused old people needing hospital investigation and care be admitted to a geriatric center or to a mental hospital?[1] The British authorities do not agree on this; for the most part, psychiatrists to whom I spoke wanted brain-damaged old people admitted to geriatric centers, and the geriatricians preferred them to be admitted to psychiatric units. Where geriatricians admit the confused old patients, fewer mental beds are needed. In the Manchester Hospital Region, the hospital at Oldham admits old people with mental symptoms to its 250-bed psychiatric service, but in Blackburn, confused old people are admitted directly to the geriatric department. Oldham uses 250 psychiatric beds whereas Blackburn serves an equal population with only 97 psychiatric beds; thus twice as many psychiatric beds were needed when old patients were admitted to psychiatry.

The trend in Britain seems to be towards admitting confused old people to a geriatric service rather than to a psychiatric service, and the frequent improvement of the mental disorder after successful treatment of the underlying physical illness supports this practice. Dr. Taylor-Brown also pointed out that a community is more willing to accept a patient back if he has been treated in a geriatric unit rather than in a psychiatric department.

Thus, in spite of differing views, there are some definite trends appearing. Although some psychiatrists still recommend treating the aged mentally ill in mental hospital, increasing numbers of these patients are now being admitted to geriatric centers. As more geriatric centers open, the number of seniles admitted to mental hospitals will become less. At the same time, more is being done to treat the confused old person in the community. Now that more help is available from consulting psychiatrists and social workers, family doctors are taking more responsibility for these patients. Many mental hospitals, like Mapperley and Graylingwell, send out consultants whenever the general practitioner seeks help. The consultant has the choice of advising the general practitioner how to look after the aged psychotic, or of admitting the patient to a day treatment center, or even of admitting him to mental hospital. In many places, he has the added alternative of referring to the geriatric department of the general hospital.

Although as yet few general practitioners look after their senile patients in hospitals, several British psychiatrists think that the senile patient provides the best opportunity for the psychiatrist to work along with the family physician—since the old patient usually has both physical and mental complaints.

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[1] "Mental Disorder in Old Age", an editorial, *British Medical Journal*, Sept. 8, 1962.

Although many seniles are admitted to geriatric services (usually with physical diagnoses) most confused old people still go to a psychiatric unit or to a psychiatric hospital, but this seems to be changing. In its Hospital Plan for England and Wales, 1962, the Ministry recommended 1.3 geriatric beds per 1,000 and 1.8 beds for the mentally ill (by 1975)[1]. Many psychiatrists now think that geriatric beds should be increased from 1.3 to 2 per 1,000 and the mentally ill beds reduced accordingly. Many psychiatrists in the Manchester Hospital Region believe that if geriatric services looked after most of the aged mentally ill, less than 1 bed per 1,000 would be needed in psychiatric hospitals for all psychiatric treatment; except in the Manchester Hospital Region, there is no evidence yet to support this contention. If the geriatric units were to admit all psychotic old people, they would require good psychiatric consultation service; acute depressions and disturbed brain-damaged people would have to be promptly transferred to mental beds.

But the care of the senile psychotic in the community seems to be improving in Britain. Day care services for the convalescent aged mentally ill have worked well. As local health authorities add more mental welfare officers, their home visiting and follow-up services improve. More hostels are planned for mentally handicapped old people, although it is unlikely that in future the mentally disordered will be rigidly segregated from other types of problems. The increasing number of health visitors and of home help with experience in psychiatry now makes it possible for the local authorities to give more support to families looking after senile relatives. Certainly the trend is towards keeping the mentally handicapped old person at home as long as possible; this can be better done with occasional emergency hospital admissions, community-based geriatric services and the aid of skilled social service workers in the community.

[1] "Care of the Elderly Confused Patient", an editorial in *The Lancet*, September 15, 1962.

CHAPTER 19

SOME REACTIONS TO THE TRENDS

A consistent pattern of change appears in the foregoing description of psychiatric services in the United Kingdom; these changes are evident not only in the mental hospitals themselves, but also in local authority and in other community services. Psychiatric care is moving away from the mental hospital —towards the community. As a result, patients are now discharged earlier—often when still quite sick; patients who formerly would have spent months or even years in mental hospital, are now treated in out-patient departments, in day-patient centers, in hostels, and in general hospitals.

The spirit and intent of this trend have been eloquently expressed in a speech by the Right Honourable J. Enoch Powell, Minister of Health,[1] when he opened a conference of the National Association for Mental Health on March 9, 1961. The Minister said, " . . . In fifteen years' time there may well be needed not more than half as many places in hospitals for mental illness as there are today. Expressed in numerical terms, this would represent a redundancy of no fewer than 75,000 beds. But that 50 per cent or less of present places in hospitals for the mentally sick—what will they look like and where will they be? We know already what ought to be the answer to that question: they ought, for the most part, to be in wards and wings of general hospitals. . . . What are the implications of these bold words? They imply nothing less than the elimination of by far the greater part of this country's mental hospitals as they exist today."

Later in the same address, he also said, "I will go so far as to say that a hospital plan makes no sense unless the medical profession outside of the hospital will be able progressively to accept responsibility for more and more of the care of patients which today is given inside the hospital . . . it makes no sense, therefore, unless the medical profession outside the hospital service can be supported in this task by a whole new development of the local authority services for the old, for the sick, and for the mentally ill and mentally subnormal . . . and then, I intend to call on the local health and welfare authorities . . . to take a hand in mapping the joint future of the hospital and local authority services."

Although he was stating his own views, the Minister was also expressing the views of many psychiatrists in Britain, including not only those attached to the Ministry, but also many in the regional hospital services. Since Mr. Powell's

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[1] *Emerging Patterns for the Mental Health Services and the Public*, NAMH, London (Proceedings Conference, 9th and 10th March, 1961).

address was delivered, his words have been loudly praised or bitterly attacked —depending on the personal views of the critic. Those who believe that today's mental hospitals will be radically changed, and that much of their present responsibilities will be taken over by services in general hospitals, and in the community, support their arguments by citing what is going on in the psychiatric programs at Chichester, Nottingham and in the Manchester Hospital Region. Even while agreeing on getting rid of the mental hospital, the members of this group differ widely on the precise pattern of services which should replace the mental hospital, and they particularly disagree on the numbers of hospital beds which would be needed. In the Manchester Hospital Region, most of the psychiatric consultants believe that, given adequate community services, and a geriatric service prepared to co-operate fully with psychiatrists, that comprehensive psychiatric care could be provided in general hospitals with only .5 psychiatric beds per 1,000. But in Oldham, where psychiatrists look after many geriatric patients, it is thought that at least 1 bed per 1,000 would be needed. The Tooth and Brook estimate (a national goal for 1975) is 1.8 beds per 1,000. Meanwhile, the 140,000 beds for the mentally ill in Britain now provide a ratio of 3.2 beds per 1,000, and the opponents of the Ministry's plans for reduction consider this about right.

Those who advocate the most radical changes draw support for their policies from the programs that have developed at Nottingham, Chichester and in the Manchester Hospital Region. These programs have developed under the guidance of such gifted leaders as Carse, Macmillan and Mackay; all these programs grew up in the course of meeting service needs—none were based on principles thought out well in advance.

University departments have contributed little to this change, but the staff of one university has produced a plan that may have great influence on future developments. During the past five years, Dr. Thomas McKeown, Professor of Social Medicine at the University of Birmingham, has been publishing the results of studies on the organization of hospitals—carried out in his department.[1] He has criticized the almost complete separation in hospital care today of mental hospital services from the acute general hospitals. In his recommendation for radical change in the organization of hospital services, McKeown pays much attention to the needs of psychiatric patients. He says, " ... (there are) two firmly rooted features of hospital tradition. One is the separation of hospitals for the chronic and mentally sick from the general hospitals. The other is the concept of the hospital as a single structure. ... Both features owe their origin to circumstances which no longer exist, and there would be considerable advantages in getting rid of them ..." "... patients who are mentally ill need not be separated sharply from those who are physically ill ... the types of institution in which the patient is placed should be determined principally by his needs." McKeown bases his plan for a comprehensive hospital on the findings of a critical study of the needs of patients in all types of hospital in the Birmingham area. His group surveyed patients in general hospitals, in mental hospitals, and in chronic care institutions. As a result, he classified these patients into four groups according to need:

1. Full hospital care required—54 per cent.
2. Limited hospital care without mental supervision—9 per cent.
3. Limited hospital care with mental supervision—31 per cent.
4. Hostel care only—6 per cent.

[1] McKeown, Thomas, "A Balanced Hospital Community", *The Lancet*, April 5, 1958, pp. 701-704.

To provide this type of service he recommended creating a comprehensive hospital that, at a single site, would look after all types of hospitalized patients from a given population. The same maintenance and special treatment facilities would be available to all; with certain exceptions, there would be a common staff; flexibility would be obtained by having a variety of buildings.

According to McKeown, the mentally ill would fare better with this arrangement than in the present mental hospital organization; it would be easier to recruit doctors and nurses (because of the attraction of the integrated mental and physical services); the comprehensive hospital would provide greater flexibility in the use of buildings and staff; there would be better opportunity for the psychiatric education of nurses and doctors and for research; the proximity of general hospital services would mean improved physical care for the mentally ill, and would counter the stigma created by the past isolation of the psychiatric patient.

Unlike many who seek closer association between medical and psychiatric patients, McKeown does not want psychiatric patients in the same building as the physically ill, but believes that being in the same complex will provide the advantages of proximity without the disadvantage of intermingling.

He wants day care services, hostel accommodation, and the integration of hospital psychiatry with the local authority services for community care and rehabilitation. He would also have the children's psychiatric units in separate buildings, but in the same area; he agrees that beds for subnormals *could* be elsewhere, and the beds for psychopaths *should* be elsewhere.

Although McKeown's ideas are intriguing and logical, as yet they are still only on paper. Some psychiatrists (like Stanley Smith, the Physician Superintendent at the Lancaster Moor Hospital in the Manchester Hospital Region) are now trying to develop comprehensive services by adding units for specialized physical treatment to their mental hospitals. Smith has added orthopedic and ophthalmic units which are used by the local consultants in these specialties. This brings non-mentally ill patients to the mental hospital for physical therapy, and improves the public's image of the institution.

The desire for closer integration of psychiatric services with other branches of medicine is not new. In *Mental Health and Social Policy – 1945-1959*, Kathleen Jones makes reference to a report entitled "The Future Organization of the Psychiatric Services" published in June 1945. This was produced jointly by representatives from the Royal Medico-Psychological Association, the Psychologico-Medical Section of the B.M.A. and the Royal College of Physicians. The report stressed that "the argument for treating psychiatry in all essential respects like other branches of medicine" was "strong and conclusive. . . . There is everything to be said for making administrative structure of psychiatry exactly the same in principle and even in major detail as that of other branches of the health services".[1]

Those who would replace the mental hospital, or radically alter it, include a cross section of all workers in psychiatry. Among these are psychiatrists who are attached to the Ministry, superintendents of mental hospitals, university teachers and some researchers. But there are many who disagree with the present trends, and who present strong arguments in opposition. Those who oppose gradually

[1] Royal Medico-Psychological Association Report on Medical Planning Committee, *A Memorandum on the Future Organization of Psychiatric Services* (privately published, London, 1945).

replacing the mental hospitals with services more closely integrated with other health programs, also represent a cross-section of people working in psychiatry; they too include superintendents of hospitals, university teachers and many researchers.

In the course of this great debate, those who oppose present trends do have some views in common with those who seek more radical change. Both sides regret that the mental hospital began in an era when mental illness was so beclouded by ignorance and superstition. They agree that the mental hospitals have, in the past, suffered from much restrictive legislation (as in the Lunacy Act of 1890), and that prior to the National Health Service Act, mental hospitals were often starved by the financial limitations of the local health authorities. Because of this, they both agree that the present mental hospitals are not good enough. Here, however, some of his critics part company with the Minister, and say that the hospitals should be improved—not abolished. They think that the separate mental hospital provides the best place for good psychiatric treatment, and that the present trend towards dividing its functions between general hospitals, day centres and other community programs will lead to chaos and to poor care.

One rather outspoken critic of the present trend is Dr. Russell Barton,[1] Physician Superintendent of the Severalls Hospital, Coldchester, Essex.

Dr. Barton believes that if the functions of the mental hospital were to be divided between general hospitals, day centres, hostels, out-patient clinics, and local authority mental welfare officers, that 25 years from now these would have to be reassembled again into something like the present mental hospital. He believes that in the general hospital psychiatric services would suffer under lay administration, and that the general nurse without psychiatric training would be unable to properly look after mentally sick patients; that if the beds of the mental hospital were distributed to general hospitals, it would be impossible to obtain enough psychiatrists; that the atmosphere of the general hospital is unsuitable for the therapeutic community.

He believes that the staff requirement at the proposed day centres could not be met, and that patients housed in hostels would suffer because of the lack of contact with professional staff. He thinks that under the proposed programs, up to ten psychiatrists per million population would be required to operate out-patient services, and that these could not be obtained; he thinks that many of the local authorities lack vital concern for the psychiatric patient. He sums up his arguments by saying, "There appear to be three basic difficulties in the way of making adequate provision for the care of psychiatric patients outside the mental hospital: firstly, the provision of trained staff in numbers vastly greater than exist today; secondly, that of management and administration throughout a large number of scattered units, so that the morale and welfare of patients and staff are maintained, along lines developed successfully in many psychiatric hospitals; thirdly, that of finance."

Although some behavioural scientists (notably Dr. Jacqueline Grad,[2] with Sainsbury at Chichester) have presented evidence in support of more community treatment, others, including Wing have been critical. Perhaps the critic who

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[1] Barton, Russell, *Trends in Mental Health Services, the Psychiatric Hospital* (Freeman and Farndale), Oxford: Pergamon Press Ltd. (1948), pp. 156-163.

[2] Grad, Jacqueline, Sainsbury, Peter, *op. cit.*

speaks with the greatest eloquence is Dr. Kathleen Jones of the Department of Social Administration at the University of Manchester. Dr. Jones has established her interest and knowledge in the field of psychiatry through two outstanding historical books.[1] Dr. Jones' arguments against assuming the disappearance of the mental hospital were expressed in an address to the Royal Medico-Psychological Association on February 15, 1962. They include the following points:

1. that the assumption that the mental hospitals are running down was based on long-term projection from short-term trends,
2. that the decline in mental hospital beds is smaller than it seemed to be,
3. that the decline is unlikely to continue,
4. that the decline has resulted from administrative change rather than clinical advance,
5. that apart from talking about closing beds, it should be noted that there are not enough beds *now* to meet the needs,
6. that the volume of work of the mental hospital is greater than ever before,
7. that we should not put too much burden on the family,
8. that the community services are unlikely to grow fast enough to meet anticipated demands,
9. that psychiatric units in general hospitals are unsuitable for most psychiatric patients, and
10. that the motivation behind the drive to be rid of the mental hospital is irrational.

In an article in *Trends in Mental Health Services*[2] Dr. Grad says, "Many psychiatrists, administrators and research workers are watching the development of the mental health service with interest, and some with a degree of apprehension. Developments in the next few years may show that the present proposals with regard to the mental hospital are retrogressive rather than progressive, and we shall have to think again."

So the great debate rages,[3] and the future of psychiatric services in Britain is not yet settled. The Ministry presses on with its program of reducing the size of mental hospitals, and of increasing the scope of community psychiatric treatment; at the same time, the critics of this program prophesy doom. To a visitor, the accomplishments at Worthing, Nottingham, Manchester and elsewhere are impressive; yet one is disturbed by the lack of evaluation of these programs. Aside from the excellent work being carried out by Sainsbury and Grad at Chichester,[4] little has been done to scientifically seek answers to the important questions. Surely it would be feasible to compare the results of treating schizophrenics in mental hospital, on the one hand, with treating similar patients in psychiatric wards in general hospitals, on the other. There should be more assessments of the effects on children of having schizophrenic or senile relatives in the home. Many psychiatrists operating psychiatric units in general hospitals believe they can develop good therapeutic milieu in such surroundings—this surely could be evaluated. Little has been published about the relative merits of hostels compared to hospitals for subnormals.

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[1] Jones, Kathleen, *Lunacy Law and Conscience, 1744-1845*, London: Routledge and Kegan Paul, Ltd. (1955), and *Mental Health and Social Policy, 1845-1959*, London: Routledge and Kegan Paul, Ltd. (1960).

[2] Grad, *op. cit.*

[3] "Future of the Mental Hospitals", *The Times* (London), April 27, 1962.

[4] Grad, *op. cit.*

A visitor looking for trends in psychiatry is greatly stimulated by what he sees in Britain; he is stimulated by the remarkable changes, the Open Door at Melrose, geriatric care in Oxford, the activities carried on at Ailsa; he is fascinated by the interest and confidence of those who argue for and against the current developments. If the programs of community care which are springing up are unwise, it would seem that the onus is on the critics to prove this by means of scientifically controlled experiments. Their words of warning have been clearly and eloquently sounded, but in a field as poorly mapped as psychiatry, eloquence is not enough. True, the authorities who are making the changes do have responsibility to critically evaluate what they are doing; they have craried out less study than one would like to see. Meanwhile, the change moves on, and it may be that time will have to make the final evaluation.

How should Canadians react to the criticisms that Dr. Kathleen Jones (and others) have made of the present trends in British psychiatry? Dr. Jones' protests must be given serious consideration. As she has pointed out, we really do not know that the present decrease in mental hospital population will continue indefinitely on its own. We must also agree with her statement that the present demands on psychiatry are greater than its resources.

At the same time, many observers will disagree with Dr. Jones' conclusion that good comprehensive psychiatric care is impossible in a general hospital; nor will everyone agree with her inference that those who support the Ministry's program, do so from irrational motives. As mentioned elsewhere, Grad and Sainsbury have produced some evidence showing that given proper safeguards, the community can, without suffering harm, absorb convalescing mental patients. Finally, empirical support accumulates for the course that the Minister has taken towards integrating psychiatry with the rest of medicine, and towards more psychiatric treatment in the community.

Canadian psychiatry should profit from what is happening in Britain. We can make use of the knowledge already gained in programs like those at Worthing, Nottingham, and in the Manchester Hospital Region. These provide useful models from which to pattern the pilot projects which should guide psychiatric progress in Canada. If Canadians set up these pilot projects carefully, they will gain information by which they can make the necessary modifications in plans for psychiatric service. Where the British programs prove useful in Canada, Canadian psychiatry will then have a head start in establishing a better program.

PART III

UNITED STATES

The following summary of a survey of current trends in psychiatry in the United States is based on (1) a review of the literature on American psychiatry, (2) several visits during the past twelve months to psychiatric centers in the United States, and (3) personal knowledge of American psychiatry.

This summary indicates trends in Federal Government and State participation in psychiatry. It makes many references to the survey and recommendations of the Joint Commission on Mental Illness and Health. It refers to specific changes in methods of dealing with psychotics, neurotics, mental defectives and the mentally disordered charged with crime. It discusses developments in general hospital and general practice psychiatry, and the progress of community psychiatric care in the United States as contrasted with community development in Britain. It makes some reference to developments regarding staff and to changes in therapeutic practice and in public attitude.

CHAPTER 20

TRENDS IN PSYCHIATRY IN THE UNITED STATES

1. Organization of Psychiatric Services

(a) *Federal*

The Federal Government in Washington has no direct responsibility for providing psychiatric services except (a) for the armed forces (including entitled veterans) and (b) for the residents of the District of Columbia. The Government does, however, exert a good deal of indirect influence on psychiatric care by granting funds for service (as well as for research and training) to State Governments and other bodies.

The Veterans' Administration administers more than 60,000 psychiatric beds; 55,000 of these are in large Federal Mental Hospitals and 5,500 are in small units in the veterans' hospitals where general medical and surgical care is provided. VA psychiatric care costs $14 a day compared to less than $5 a day for the average state hospital care.

Recently the Veterans' Administration has decided that in future psychiatric beds should be located in general rather than in special hospitals, and that the VA will build no more large mental institutions. This new policy provides for 250 psychiatric beds in each future 750-bed VA hospital.

Aside from the Veterans' Administration, Federal participation in psychiatric services is confined to the Department of Health, Education and Welfare; the funds available to this Federal Department are administered in one division—the National Institute of Mental Health (NIMH). In 1955 the National Institute of Mental Health sponsored the Mental Health Study Act known as Public Law 182, which made available funds to establish the Joint Commission on Mental Illness and Health. This Commission was directed to analyze and to evaluate the needs and resources pertaining to mental health, and to make appropriate recommendations. For many years there had been constant agitation for government action in the field of mental health and this had resulted in the Joint Commission. The pressure came from the American Psychiatric Association, and from such citizen-sponsored mental health groups as the National Association for Mental Health. It was hoped that, with Government help, a radical reform of mental health care could be achieved.

In the preamble of the Act, the state of the existing psychiatric services was deplored, and the need for change pointed out. This statement complained of:

(1) the existing patterns of custody rather than treatment,
(2) the lack of facilities for early treatment,

(3) the shortage of personnel,
(4) the failure to apply present knowledge,
(5) the lack of out-patient services,
(6) the fact that too many old people were being kept unnecessarily in mental hospitals.

During the study, which lasted for six years, the Commission employed 200 consultants, and it has published 11 volumes on this project.

The recommendations of the Joint Commission include the need:

(1) to liberalize policies on who might participate in psychiatric treatment,
(2) for more research,
(3) for better use of manpower,
(4) for more public and professional education,
(5) for earlier treatment,
(6) for more Federal aid,
(7) for more community services,
(8) for smaller psychiatric hospitals with no hospitals larger than 1,000 beds,
(9) to change the laws on admission to mental hospital.

Quite apart from its connection with the Joint Commission, the NIMH has, for the past several years, administered mental health grants made to States (and to other organizations) to assist community psychiatric services, for the education of psychiatrists, and for the psychiatric education of family doctors. It is now planning a large extension of these grants-in-aid. Bills are now before Congress which would provide great increases in the matching grants of funds for research and for training.

(b) *State*

The States administer 94 per cent of the psychiatric beds that are not operated by the Federal Government. Because of the amount of State funds involved, and in response to complaints from voters, the Governors of the States have maintained an active and continuing interest in mental health and have established the Governors' Conference on Mental Health which meets regularly to discuss State mental health problems. Despite the interest of the State Governors, the proportion of state budgets allocated to mental health has not increased proportionately during the last 15 years; it remains between 3 and 4 per cent of the total state budget.

There are 279 state mental hospitals, which house a total of more than 500,000 mentally ill patients. From one state to the next, there is a wide variation in the policies governing hospitalization; in some states, the number of mental hospital patients per 100,000 population is several times larger than in others. Of the more than half million state hospital psychotics, 30 per cent of the patients are older than 65 years (compared to 10 per cent of the general population), 80 per cent are considered chronic (usually interpreted as more than two years in mental hospital), more than half of the patients are judged to be receiving custody rather than treatment. Twenty-nine state hospitals have no psychiatrists on staff. The average daily cost in 1961 was said to be $3.61 for a day patient; in three states the daily cost was less than $2.00.

In addition to 279 state hospitals for the mentally ill, there are 136 private psychiatric hospitals, in which per diem cost is higher, but which, for financial

reasons, are not available to the average citizen. Many of these private institutions, in fact, are considered to be poor treatment centers.

Besides the hospitals for the mentally ill, there are 264 institutions for mental defectives, housing more than 100,000 patients. In addition, there are more than 40,000 mentally defective patients scattered throughout the mental hospitals for psychotics. An estimated cost per patient in the institutions for the mentally retarded is $4.24 a day. Thus, the average cost of hospitalization per day in the United States for all of the mentally disordered is about $4.00 compared to $14.00 in the VA hospitals and to $25.00 in general hospitals.

With this great variation in policy, in practice, and in the amount of money spent from state to state, it is difficult to establish trends common to most state mental hospitals. Some leaders in American psychiatry (including some senior government officials) have predicted that within 25 years the mental hospital, as is now known, will have disappeared; just what will take its place has not been made quite clear. In some states, the officials have recently removed the mental patients from county homes and placed them in mental hospitals, whereas in other states it has been thought progressive to transfer mental patients from mental hospitals to county homes. Many states (particularly California) make vigorous attempts to keep the mentally ill old people out of mental hospitals. The results of several surveys have indicated that at least 40 per cent of the old people in mental hospitals need not be there—these patients being kept in hospital more for social than for medical reasons. On the other hand, the Joint Commission has recommended that the 1,000-bed hospitals be used for chronic patients, particularly the aged mentally ill; this suggestion has created much controversy, and a lot of adverse comment. All this indicates great dissatisfaction with present arrangements for the mentally ill in the United States, but no generally agreed on plan for improvement.

There is a definite trend in America towards more voluntary admission. During a ten-year period, the State of Connecticut changed its admission practice from (in 1950) admitting 96 per cent on certificate—with 4 per cent voluntary, to (in 1960) a ratio of 25 per cent admitted on certificate—with 75 per cent voluntary.

Meanwhile, the Governors' Conference has issued a strong statement, calling for improvements—particularly in regards to more personnel, more money for research, better rehabilitation programs, and reform of admission procedures.

In mental deficiency, trends toward improvement have been sparked by strongly organized parents groups, and by warm support from the present administration in Washington. The current trends are towards the development of sheltered workshops. Congress has been asked to appropriate more than $200,000,000 annually to improve the care of the mentally retarded. This money would be used to supplement the income of the working mentally retarded, to provide $51,000,000 for research, and for other assistance in the care of the retarded.

(c) *Psychiatric Units in General Hospitals*

The Joint Commission made a strong recommendation for more psychiatric units in general hospitals, recommending such units in every hospital of more than 100 beds. At present, 515 general hospitals (11 per cent of the total) have psychiatric units containing a total of 22,000 patients. Annually, there are more

than 200,000 patients admitted to these wards, equalling the number of admissions to state mental hospitals. The average length of stay of patients in psychiatric units in general hospital is about 15 days, compared to one estimate of 677 days for the average length of patient stay in state hospitals. (It must be noted that the latter figure includes the length of stay of the 80 per cent chronic patients; the average length of stay of acute patients in state hospital is probably less than two months).

There has been a great increase in the number of units during the past 20 years (an increase from 135 in 1961 to 515 today). These units vary in size and function. Some are chiefly receiving centers for the large state hospitals; others concentrate on intensive treatment programs. Some psychiatric services in general hospitals consist of a few beds set aside on the medical wards, rather than independent units. The NIMH now provides grants to set up additional units; one State (Georgia) sponsors 100-bed units in general hospitals. Finally, there is a trend, in some general hospitals, towards setting up 24-hour service for psychiatric emergencies, including patients who walk in off the street.

(d) *Neuroses*

Because of the lack of precision in defining neuroses, it is very difficult to get an accurate picture of neurotic disorder in America today; the usual estimates include from 5 to 8 per cent of the adult population. Nominally, neurotic disorder is treated by private psychiatrists and in mental health clinics. Obviously, however, most neurotics present their complaints to general practitioners, and for many reasons, including the shortage of psychiatrists, most neurotics, for better or for worse, receive no treatment other than that given by their family doctors. This has caused many psychiatrists, as well as some leaders in the Academy of General Practice, to request better instruction in psychiatry for family doctors; reference will be made later to NIMH grants-in-aid for this purpose.

(e) *Alcoholism*

It is estimated that there are nearly 5,000,000 persons in the United States who, by common definition, could be called alcoholics. Of the variety of state and private organizations trying to help alcoholics, the best known is Alcoholics Anonymous. There is no uniform state or municipal pattern of organizing diagnostic and treatment services for alcoholism, and there is no central source of funds. The explanation for this lack of consistency is in the nature of the problem—alcoholics do not belong to a single disease entity—we are dealing with an administrative rather than a clinical grouping.

(f) *Child Psychiatry*

Stimulated by a desire to prevent those mental disorders which would later lead to adult psychoses, child psychiatry developed in America about 40 years ago; later the child psychiatrists became more interested in treating the illnesses of children than in preventing mental illness in adults.

Hospital facilities for psychotic children are limited; there are less than 3,000 children among the 500,000 psychotics in state hospitals. Compared to in-patient units, out-patient psychiatric services are much better developed for children, who comprise more than half of the 400,000 patients seen annually in mental health clinics.

(g) *Community Psychiatry*

In the United States there is a definite trend towards increasing out-patient treatment of the mentally disordered; this has been influenced by the reported

success of British programs for community psychiatric care. The Joint Commission has recommended one psychiatric clinic for every 50,000 population; at present there are 1,400 such clinics in the United States, and an additional 2,200 would be needed to achieve the recommended ratio.

Because of the nature of the NIMH grants for community clinics, the public health authorities (as distinguished from the state mental health authorities) are becoming interested in the mental health field. This newly developed interest in mental health has resulted in a trend towards more mental health education for medical officers of health and for public health nurses. Some states are developing state-financed community mental health centers to co-ordinate all the local out-patient services; Minnesota has 17 such centers.

Despite pressure for more community involvement, only 10,000 of the 500,000 psychotics under state supervision are now boarded out under family care. Hoping to expand all types of community mental health care, NIMH has established grants to states for planning future facilities; already 23 of the 50 states have applied for these grants to help with their long-range plans.

(h) *Family Physicians*

For a variety of reasons (probably not all related to an interest in the welfare of the psychotic), there has been a great surge in interest in psychiatry among the executive groups of the leading medical organizations in the United States; among others, these include the American Medical Association and the Academy of General Practice. No comparable increase in interest on the part of individual members is evident.

It is estimated that more than $206,000,000 is received by general practitioners each year for medical care given in their offices to patients who suffer from psychiatric disorder; this is three times the amount of money paid to specialists in psychiatry. Partly because of this, the NIMH has set up training grants for general practitioners wishing to improve their knowledge in psychiatry, and the American Psychiatric Association is sponsoring seminars in psychiatry for general practitioners.

(i) *Psychiatry and Crime*

For more than 100 years, controversy has waged in America over the mental health of individuals charged with crime. The battle began in 1836 when Prichard pointed out that some habitual criminals had gross emotional disturbances, even though intellectually clear. The argument was on the issue of this group's legal responsibility for offences committed.

Most of the states follow the McNaughton principle, which originated in Britain in 1841. In effect, this established that an offender was responsible if he knew what he was doing at the time of the offence, and if he knew what he was doing was wrong—notwithstanding his emotional state. In 1870, the State of New Hampshire rejected this rule, acceding to the principle that a person was not responsible for an act resulting from mental illness. The other states, however, accepted the McNaughton rule, although several later altered this by adding the ill-fated irresistible impulse defence.

The Durham decision in the District of Columbia in 1954 made use of the New Hampshire definition of responsibility, insisting that the offender was not

responsible if the act resulted from a mental disorder, even though he knew what he was doing, and that it was wrong. This judgment was accepted with enthusiasm by most (although not all) physicians interested in forensic psychiatry. Several states have since introduced bills to implement the Durham decision, but, up until now, these have been rejected in all states except Vermont.

Meanwhile, a committee of the American Law Institute reviewed the McNaughton rules, and the Durham decision, and rejected both in presenting its own model act. The majority report (with the psychiatrists on the committee dissenting) states that all mental disorder could be an excuse from responsibility, but with definite qualifications. In effect, the Institute report said that an offender was not responsible if he was mentally ill at the time of the offence, and because of this lacked substantial capacity to appreciate the criminality of his acts or to conform. From the above provision, the model law specifically excluded individuals whose only mental symptom was repeated criminal activity (in a word—the psychopaths).

Most American psychiatrists consider the American Law Institute's model set an improvement over the McNaughton principle, but definitely inferior to the Durham decision. They believe that the Durham principle is the only policy permitting the psychiatrist to properly communicate his professional opinion to the court—otherwise he is restricted by the court, and is much less useful. To this, the answer of the lawyers was that the Durham decision takes the responsibility out of the hands of the judge and jury, improperly giving it to those presenting medical evidence; so the battle wages.

(j) *Staff*

Although there are 12,000 specialists in psychiatry in the United States, less than 2,000 of these are in state hospitals, even though the state hospitals look after nearly 700,000 mentally disordered. Most psychiatrists are in private practice and nearly half of those in private practice are located in areas which contain less than a fifth of the country's population. In other words, the uneven distribution of specialists in psychiatry in the United States prevents their proper use. One of two state mental health authorities permit private psychiatrists to treat their own patients in state hospitals; although there is much talk about having private psychiatrists practise in state institutions, little has been done about it yet.

For the more than 600,000 patients in mental institutions in America, there are less than 3,000 graduate nurses and only about 2,000 of these are registered nurses. These 2,000 registered nurses in mental hospitals are from the total of 300,000 registered nurses in the nation, and the 8,000 trained nurses in mental hospitals compare to 90,000 relatively untrained attendants in these same institutions.

(k) *Social Workers*

Of the 4,000 psychiatric social workers in the United States, only 1,300 are working in the institutions, which now house more than 600,000 patients. In 50 schools of social work, the NIMH is spending about $4,000,000 a year training psychiatric social workers. A number of social workers engaged in psychiatry are doing private case work. The trend in social work training and practice is

towards less individual case work, more group work, more foster care, and toward development of half-way houses and community services.

(l) *Therapy*

During the past 100 years, psychiatric therapy in America has gone full cycle. After starting in 1850 with the moral treatment proposed by America's original 13 superintendents, during the latter part of the 19th century, therapy deteriorated to being mostly custody; then, during the second 25-year period of the 20th century, psychotherapy increased in importance (especially in private psychiatry); more recently, shock therapy (insulin and electroshock) moved ahead; still later drugs and now social therapy seem to be in the ascendency.

Today many mental hospitals are stressing milieu therapy with the hospital becoming a "therapeutic community". In this setting (after ideas imported, in part, from Britain) the patients and staff work in close harmony trying to resocialize the mentally disordered. Industrial therapy has not progressed in the United States as it has in England—chiefly because of state reluctance to pay for patient labour, and because of fear of labour union objections. Within the state hospitals, many changes are taking place. Day hospitals (with patients sleeping at home) are developing; there are 76 known day centers now in the country.

Open hospitals have not developed as in Britain—only two state hospitals are entirely open. Even the psychiatric units in general hospitals (almost all of which in Canada and in Britain are open) have many restrictions. They either restrict the type of patient admitted, or have part or all of the psychiatric wards locked. Yet influenced by the British experience, there is a definite trend towards more open doors, both in psychiatric units and in state hospitals.

The training programs for psychiatrists are much more highly developed in the United States than in Britain; most medical schools have graduate training programs. Many state mental hospitals are affiliated with these, and send their untrained medical staff to university courses for weekly or even daily lectures. Unfortunately, many of the psychiatrists, as soon as they have been registered by the American Board of Psychiatry, leave the state hospitals and enter private practice. The Joint Commission on Mental Illness and Health is recommending that 2.5 per cent of the funds spent on psychiatric services be set aside for training of all types of staff.

Thanks to NIMH, there has been a great increase in the funds available for research; the Joint Commission is also recommending 2.5 per cent of all funds for psychiatric care be spent on research.

(m) *Attitudes*

The public attitude towards mental illness has not been liberalized to the same extent in America as it has in Great Britain. In the United States, the image of psychiatry and of the psychiatrists tends towards one or other extreme—either the Hollywood psychiatrist with the couch, or the Snake Pit. The Joint Commission plans to do something to improve this image—especially among some non-psychiatric physicians.

(n) *Costs*

The Joint Commission has estimated that the direct and indirect costs of mental disorder in America total more than $3,000,000,000 annually. Even though governments are becoming aware of this great cost, little has been done to cut down the loss by increasing the amount of money spent on treatment, research, and prevention. The proportion of national income spent on psychiatry still is less than a tenth of 1 per cent—no increase proportionally during the past 15 years. Nor has the 3 per cent which state budget makers allocate to psychiatry increased during the 15 years. It has been estimated that the amount spent on liquor is nine times as great as the amount spent on psychiatric research.

The private medical care agencies reflect the common unwillingness to accept psychiatric care in the same manner as physical care. Whereas 54 of 79 Blue Cross groups pay something for mental illness, only 19 of the 79 accept mental illness on the same basis as physical illness. At the same time, although 39 of 64 Blue Shield agencies will pay something towards the medical bill, only 15 of the 64 accept psychiatric bills on the same basis as other medical accounts.

It is estimated that to meet the average cost of a psychiatric illness without state aid, an American family must be earning in excess of $10,000.

2. Summary

In this summary of trends in American psychiatry, the following points stand out:

(a) There is no uniform picture of American psychiatry. Differences in practice and standards between state and private practice, between Federal and State services, and between different parts of the country are much greater in the United States than in Canada, and very much greater than in Britain.

(b) Those demanding change in psychiatry in the United States are more vocal than in either Canada or in Great Britain; they have the backing of the Federal Government, and great sums of money with which to bring about change—yet because of local conditions, their task is probably harder than that of those demanding reform in Britain and in Canada.

(c) At present, the recent report of the Joint Commission is being used to spearhead this demand for change. By and large, the demand takes the form of calling for more Federal aid for research, training, recruitment, and for the development of community services.
It remains to be seen whether the current enthusiasm for change will be maintained until these changes occur; it could be.

APPENDIX 1

STUDY OF MENTAL ILLNESS: THE GENERAL PRACTITIONER[1]

by

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A general practitioner has been compared to a gate-keeper. He is the person to be consulted first about physical health problems and generally about mental health ones also. In some cultures the gate is a wide one and patients may slip through without having contact with the general practitioner. In other cultures the gate is very narrow and the general practitioner deals with most of the problems himself. By and large, Saskatchewan, the site of the present study, would fall into the latter category. In the smaller towns and villages no specialist is immediately available and referral may involve a journey of several hundred miles. Under those circumstances we might expect to find that general practitioners handle a good deal of work which is elsewhere considered to fall under the specialists' ambit. In the mental health field the number of psychiatrists available in Saskatchewan is comparatively small. There are only three private psychiatrists; the remainder (17 specialists; 27 in various stages of training) being employed by the Government or the university.

Other studies have indicated that the percentage of "psychiatric" problems seen in general practice is high. How high depends not only on the criteria adopted but also on the method of collecting data. Kessel (5) showed that by varying the criteria the percentage of psychiatric illness ranged from 5 to 52 per cent in the same collection of patients. The latter figure was reached by including the so-called psychosomatic illnesses. The data, of course, may be expressed in various ways: for example, in terms of a series of consecutive patients, or of consecutive consultations, or again of consecutive illnesses. Alternatively the prevalence can be stated as a fraction of the total patients registered in the practice. All these different methods of expressing the data naturally give rise to different figures. It is fair to say that however one looks at it the general practitioner must see and treat a wide variety of emotional disturbances. Good studies of general practice in North America have been made (2, 10), but more attention to the psychiatric aspects has been paid in the British literature which is now quite extensive. A useful bibliography is provided by Kessel and Shepherd (6). Primrose (11) has given a detailed description of emotional disorders in a Scottish practice. Pasamanick (8, 9) and his co-workers have made valuable point prevalence studies.

[1] Study carried out under the auspices of the Royal Commission on Health Services, Ottawa, Canada.

Purpose of the Study

The purpose of this study of the patterns of the general practice in the Province of Saskatchewan was to find out more about the mental health of Canadian communities, and the kind of facilities which might be valuable in the future. Specifically, a questionnaire was directed to solicit information from the family doctor concerning the content of his practice, his methods of treatment with emotional disorders, patterns of referral, and his opinion about attitudes towards mental illness and the use of allied professionals.

Method of Study

In March 1962 all physicians who were members of the College of General Practice or members of the Section of General Practice of the Saskatchewan College of Physicians and Surgeons were sent a questionnaire under the signature of Doctor D. G. McKerracher, Professor of Psychiatry, University of Saskatchewan. The initial response to this questionnaire was good and further questionnaires were returned when follow-up letters were mailed to the doctors. Over half of the doctors completed the questionnaire. The results of this questionnaire pertain only to the doctors surveyed and it would be illogical to generalize conclusions beyond those physicians surveyed. A total of 250 responses were obtained. An additional 22 forms were returned stating that the practitioner had retired or was now a specialist. The information was coded and punched on to standard I.B.M. cards and preliminary runs have been completed. The present report deals with the 'straight' runs on the data.

Background Characteristics of the General Practitioners

Of the total of 250 general practitioners in the survey, 9.6 per cent had graduated prior to 1929; 10 per cent between 1930-1939; 22 per cent between 1940-1949; 53.2 per cent between 1950-1959; 3.2 per cent since 1960, and 2 per cent of the doctors did not indicate their year of graduation. There were 85.6 per cent who indicated that the majority of their work involved only general practice. Over 93 per cent indicated that at least 80 per cent of their work was involved with general practice. The results then of this questionnaire can be assumed to be representative of the work of a large body of general practitioners in this Province.

The physicians were asked to indicate the extent of their interest in psychiatry. No response came from 1.2 per cent; however, 80 per cent of the physicians indicated that their interest in psychiatry was either moderate or considerable. Only 3.6 per cent indicated that they had no interest in psychiatry. The physicians were also asked if they had ever contemplated becoming a psychiatrist. Three-quarters (75.6 per cent) said they had not and approximately one-quarter said that they had at one time thought they would become psychiatrists. If the results of the two preceding questions are considered together, then it may be assumed that physicians in this survey have an active interest in psychosomatic problems of their patients, and in the psychiatric and social components of illness.

Content of Practice

The physicians were asked how many calls of all kinds they had in the course of a week. On an average each physician had 142 calls from patients

per week. Included in this figure were office, hospital and house calls. When the physicians were questioned about the number of referrals to a psychiatrist, they reported that they had referred a total of 920 patients to the psychiatric ward of a general hospital, 1,241 patients to a mental hospital, 1,775 patients to a mental health clinic, and 766 patients to a private psychiatrist in the course of the previous year. The total number of referrals is 4,702 patients.[1] It is interesting to compare this figure with the number of patients with emotional and psychiatric problems whom they admitted and treated by themselves in the general beds of a general hospital. This total was 4,200. These figures mean that on the average each physician reported that he had referred 3.7 patients to the psychiatric wards of a general hospital, 5.0 patients to the mental hospital, 7.1 to a mental health clinic and 3.1 to a private psychiatrist, while 16.8 had been treated by the physician himself in the general ward of a general hospital, all in the course of the previous year. Six per cent of the referrals by the physicians were designated as having suicidal tendencies, and a little over 6 per cent were designated as being dangerous. General practitioners were also asked how many patients they had seen in the previous year who were senile or arteriosclerotic. The average practitioner reported 33.1 patients in these categories. On the average 2.8 patients were sent to a mental hospital. Approximately two-fifths (41.2 per cent) felt that such patients should be treated in a mental hospital, whereas an equal proportion (46.5 per cent) felt that such patients should not be treated in such institutions.

The physicians were asked to describe the content of their practice under the following four headings:

(1) Those with a definite psychiatric disorder, such as a neurosis, psychosis, or behaviour disorder.

(2) Those exhibiting mild emotional reactions essentially to stress in the environment.

(3) Those showing an excessive or inappropriate emotional reaction to physical illness.

(4) Those showing physical illness only with no psychiatric overlay.

While the estimates of patients in these categories varied considerably no physician felt that he was dealing only with physical illness. About 40 per cent of the physicians felt that more than 10 per cent of their practice consisted of definite psychiatric disorders. Half of the physicians felt that from one-quarter to one-third of their practices were involved with mild emotional reactions to environmental stress, and about half (48.8 per cent) felt that a quarter to a third of their practice was involved with excessive or inappropriate emotional reaction to physical illness.

The physicians were asked about the number of patients whom they saw in the course of a year, who were addicted to drugs or alcohol or who were mentally deficient. The average physician reported that he saw 12.6 cases of alcohol or drug addiction and 9.4 cases of mental retardation.

[1] The totals were obtained by summing individual returns. They do not necessarily refer to different individual patients as the same patient may have been seen by more than one practitioner.

Treatment of Patients

The physicians in the survey were asked to indicate whether they treated patients with emotional disturbances or not. Ninety-six per cent of the physicians answered that they did treat such patients. The main types of treatment were: an attempt to give insight and understanding of conflicts underlying illness—86 per cent; support and reassurance to the patient—89 per cent; social treatment and efforts to make changes in the environment of the patient—55 per cent; the use of drugs—92 per cent; and other techniques—14 per cent.

The physicians were asked both about the effectiveness of their own treatment of patients who had primarily emotional disturbances and of referrals which they made to psychiatric specialists. There was considerable variation in their responses. Taking the general practitioners' treatment first, 17 per cent of the physicians felt that at least 50 per cent of their patients with emotional problems recovered. A further 46 per cent thought that 50 per cent of their patients were greatly improved. Essentially there was no appreciable difference in the response of the physicians concerning the effectiveness with which they perceived themselves handling emotionally disturbed patients as against their conception of the effectiveness with which the psychiatrist handled their referrals. It must be pointed out, of course, that the two populations are not identical.

The physicians were asked to assess the effectiveness of selected types of psychiatric treatment. Of the responses concerning drug therapy 11 per cent felt that this type of treatment was extremely effective, 74 per cent moderately effective, and 10 per cent slightly effective. Seventeen per cent of the physicians felt that psychotherapy was extremely effective; 56 per cent felt that such treatment was moderately effective, and 19 per cent felt that such treatment was slightly effective. Shock treatment was also deemed to be effective; 30 per cent of the physicians said that the treatment was extremely effective, 49 per cent moderately effective, and 12 per cent slightly effective. Manipulating the environment or social therapy of the patient was not deemed to be too effective by the physicians; 12 per cent felt that such treatment was extremely effective, 31 per cent moderately effective, and 46 per cent slightly effective. Ranking the type of psychiatric treatment in order of perceived effectiveness by the physicians the following rank ordering is obtained: drug treatment, shock treatment, psychotherapy, and social therapy.

The physicians were asked to assess the type of treatment and facilities which they would like to see in the future. Eighty per cent of the physicians questioned felt that the result of their own or the psychiatrist's treatment could be improved; 11 per cent thought that such treatment could not be improved, and the remainder did not reply to the question. The physicians were asked if they had adequate facilities and prompt psychiatric advice, and were adequately paid, if they would like to treat more such patients than they currently do. Twenty-eight per cent of the physicians said that they would like to treat all or most of the patients whom they presently referred to a psychiatrist, while a further 46 per cent indicated that they would like to treat some more patients in this category. The remainder were for maintaining the status quo. Concerning the treatment of psychiatric patients, physicians were asked where such patients should be treated and whether such patients should be treated in general hospitals. Over half of the physicians (56 per cent) felt that all or most psychiatric patients could be treated in general hospitals. One-third replied that

about the same number of patients who are currently being treated could be treated in such hospitals, and the remainder indicated that such facilities were unsuitable for such treatment.

Patterns of Referral

The patterns of referral of patients with psychiatric disorders seen by general practitioners have been cited in a previous section headed 'Content of Practice'. However, additional information was sought from the practitioners. The physicians in the study were asked to assess current patterns of referral of patients to psychiatrists or facilities for patients with psychiatric illness. The reasons the physicians gave for referring patients to psychiatrists were: lack of facilities in their own offices—54.8 per cent; lack of time—56.4 per cent; inadequate remuneration for such treatment—6.8 per cent; inadequate response to treatment by the patient—68 per cent; and other reasons—46 per cent. The physicians were asked also if they felt psychiatrists sometimes took over their patients and did not return them. Only 5.2 per cent of the physicians felt that this pattern occurred frequently; 24.4 per cent felt that such a pattern occurred occasionally and the majority of 66.4 per cent felt that this never happened at all. The physicians were then asked to list the type of preferred relationship which they would like to see operate between the general practitioner in the community and the psychiatrist. Approximately one-fifth of the physicians (18.4 per cent) wanted the psychiatrist to take over their psychiatric cases completely. Only 6.4 per cent of the physicians wanted to keep their patients completely to themselves; thus approximately 75 per cent of the physicians wanted a pattern of referral in which both the psychiatrist and the general practitioner took an active role in the treatment of patients.

Community and Allied Professions

The physicians were asked to indicate other professional specialties which might be involved in the rehabilitation of the mentally ill. These specialists are ranked in importance by the response given by the physicians and were: the patient's family—92 per cent; educational psychologists—74.8 per cent; members of the clergy—68.8 per cent; public health nurses—65.2 per cent; teachers —45.2 per cent; and lawyers or police—21.2 per cent.

The doctors were asked about their patients' expectations of them. Almost three-fifths (58.8 per cent) felt that most of their patients expected that the general practitioner should treat psychiatric illnesses; 28 per cent replied that some of their patients felt this way, and the remainder of the responses were in the negative categories. It was interesting to note that about 60 per cent of the physicians felt that patients were commonly anxious or resistive to the idea of seeing a psychiatrist. Only about one-third felt that most patients did not object to seeing a psychiatrist. In this matter public attitudes may well be changing. Almost one-half of the Wheat Pool respondents(1) indicated that they considered the psychiatrist the most important person in the treatment of the "mentally ill and emotionally disturbed". Only 33 per cent so designated the family doctor.

Discussion

Nunnally (7) states that survey results show that the public considers the general practitioner to be the first person to contact for advice about mental

health problems (cf. 1). In the present study this was not investigated directly. However, some 60 per cent of the physicians indicated that most of their patients felt that the general practitioner should treat emotionally disturbed people, and the practitioner group as a whole was favourably disposed to the idea that they might increase the number of such patients treated by themselves, provided that adequate facilities and psychiatric advice were available. Only about 25 per cent were in favour of maintaining their status quo, the others favouring treating at least some more of these patients.

The interest claimed by the respondents in psychiatry is considerable and is impressive considering that 272 responses were obtained out of a total number of 488 general practitioners (56 per cent). It is striking that 80 per cent of the physicians indicated that their interest in psychiatry was either moderate or considerable. Granted that there might be some tendency to pay lip service to psychiatry it is notable that 25 per cent claim that they had at one time thought of becoming a psychiatrist. Considering the minor place psychiatry has held in the medical curriculum this figure would seem to support the idea that there is a genuine considerable interest amongst this group in psychiatric matters. The situation in this respect contrasts sharply with the difficulty which the Province of Saskatchewan has in recruiting psychiatric specialists. It may be suggested, however, that it is not the specialty which is unattractive but that other factors such as salaries and the conditions of employment deter many potential recruits. At any rate, it was notable that in the United Kingdom recruitment in psychiatry multiplied exceedingly following the introduction of the National Health Service which essentially put psychiatrists on a par with other specialists.

It was mentioned previously that it is difficult to estimate the prevalence of emotional disorders in patients seen by general practitioners. One reason for this is that the term 'emotional disorder' is a vague one. Practitioners were asked, however, to make an approximate estimate of the number of their patients in each of the four categories previously outlined. (The categories were suggested by a group of the general practitioners.) The amount of variation in the responses indicated how difficult general practitioners find it to assign patients even to simple broad categories of this kind. The figure for the prevalence of definite psychiatric illness obtained by averaging the percentage estimates is, however, about 10 per cent which is remarkably close to Kessel's (5) figure of 9 per cent for what he calls "conspicuous psychiatric morbidity". About 25 per cent of their patients are estimated by physicians to be suffering from mild emotional reactions to environmental stress, while excessive or inappropriate emotional reactions to physical illness account for about another 15 per cent. This leaves about half of the patients in their practice who fall into the category of having physical illness without any severe emotional overlay. *This gives a strikingly high estimate of emotional disorder in general practice, but one that is not out of keeping with the results of previous studies.*

Some estimate of what the general practitioners do with their emotionally disturbed people can be obtained from their figures concerning referral, and those admitted and treated by the practitioners themselves. The total number of referrals to psychiatrists made in the previous year was 4,702. These consisted of 920 to the psychiatric ward of a general hospital, 1,241 to the mental hospital, 1,775 to the mental health clinic, and 766 to a private psychiatrist. The total number of patients treated by the general practitioners themselves in hospital almost reached the total number of referrals, and in fact since presumably not

all of these 4,702 patients were admitted to hospital *it would appear that general practitioners admit and treat more emotionally disturbed people in medical wards than they refer into psychiatric hospitals.* It is interesting to note too that the number of referrals to private psychiatrists is relatively high when we consider that there are only three private psychiatrists in Saskatchewan, and that there are at least seven times that number available for out-patient consultative work under the Government or university services. We did not enquire into the reasons for this.

There are some other facts of note in the information given by the practitioners. The combined estimate for all the respondents would suggest that this group of practitioners have seen 3,148 patients suffering from alcoholic or drug addiction, and 2,342 mental defectives in the previous year. In that time they had also seen 8,282 senile or arteriosclerotic patients, and of this group had sent 691 to the mental hospital. The figures, of course, might be inflated somewhat by one patient being seen by several doctors, but nevertheless they do suggest a considerable acquaintance with these conditions. An odd finding is that they claim to have referred a total of 266 suicidal patients and 287 dangerous ones in the course of the previous year. All psychiatrists would agree that dangerous patients are much less frequent than suicidal ones, and it is hard not to conclude that the comparatively large number reported by the physicians reflects their own anxiety and indicates that old myths die hard.

The evaluation of current facilities and practices on the whole reflect an optimistic attitude toward the psychiatric patient which would almost certainly not have been recorded twenty years ago. Fifty-six per cent of the respondents felt that more psychiatric patients than at present could be treated in general hospitals, while about 40 per cent felt that senile patients whom they were presently referring to mental hospitals could be treated in the general hospital. Physicians were also quite optimistic about the results of treatment. On the average, both for patients treated and for referrals they feel that about 65 per cent are recovered or much improved, and about 35 per cent the same or worse. The last named category accounts for about 10 per cent of each group. In patients treated the main treatment emphasized was the use of drugs, mentioned by 92 per cent of respondents, but attempts to give insight and understanding of conflicts underlying illness and of support and reassurance follow closely behind with 86 per cent and 89 per cent respectively. When asked about why they refer to psychiatrists it might have been expected that the main reason would have been inadequate response to treatment. While indeed this category was checked by 68 per cent of respondents, lack of facilities and lack of time were checked by 54.8 and 56.4 per cent respectively. Rating the psychiatrists' treatments, drug therapy again came out on top being related as moderately to extremely effective by 85 per cent of the respondents. Psychotherapy and E.C.T. follow with 79 per cent and 73 per cent respectively, but manipulation of the social environment gets only a lowly 43 per cent.

The results of this study confirm that the amount of emotional disturbance amongst the patients which a general practitioner sees is high. It indicates that in this group of general practitioners at least there is a considerable interest in treating those patients. Only 18.4 per cent of the respondents wanted a psychiatrist to take over their psychiatric cases completely. The others all wanted some degree of collaboration or else treatment completely by the general practitioner. The results in this respect are similar to those reported by Nunnally (7). He found that the majority of general practitioners feel that they are trained and equipped to deal with many of the "mental" problems which they encounter, and

he pointed out that they probably exert selective influence on the clientele of mental specialists. There is a great need for further studies to be done on these patients, the problems which they present, and the outcome of their treatment. It is plain that the number of psychiatrists will not in the foreseeable future be sufficient to deal with all of these cases, and that any measures which will assist the general practitioner in dealing with them should receive careful consideration. It seems probable that the general practitioner of the future will be more strongly oriented towards psychiatry in view of its developing place in the medical curriculum, and it is likely that a change has been taking place over the years. If this hypothesis is correct there should be marked differences in attitudes and opinions between general practitioners who graduated recently and those who qualified some considerable time ago. This is a hypothesis which we propose to test in a later analysis of the same data.

It is rather fascinating that the results of treatment as reported by this group are similar to the results found by Eysenck (3, 4) when he summarized a large number of reports dealing with neurotic patients. Eysenck who approached the problem with a skeptical attitude towards psychotherapy pointed out that in the study of Denker the results of treatment by general practitioners seemed to be almost identical with those obtained by psychiatric specialists, and that the over-all rate of recovery or considerable improvement for any treatment was around 70 per cent. Of course, the populations compared may not have been identical and the results of treatment were not evaluated by any objective means. This in fact is clearly a topic for continuing research.

We may end by noting that Kessel and Shepherd (6) found that the age prevalence of neuroses in general practice and in referred out-patients differed markedly. In the latter group there was a falling off in the older age ranges. These workers thought and this seems a very reasonable assumption that this indicated selective referrals by the general practitioners. They said "It seems clear, however, from the difference in age distribution of the neuroses in hospital and general practice that some form of selective referral of young people must occur. Although practitioners vary considerably in the number and types of neurotic cases which they refer to hospital, the family doctor must look after most of his neurotic patients; this may indeed be the most desirable arrangement. In these circumstances a closer liaison between a general practitioner and a hospital psychiatrist could not fail to help the former, and might provide the latter with experience of a more representative neurotic population than he is accustomed to meet. Only on the basis of their co-operation can there be developed the many socio medical studies on which further knowledge depends". While the number of psychiatrists available alone would preclude them from exclusively treating the large population of emotionally disturbed patients seen in general practice, it is mandatory that these patients be the subject of further study; in this the special skills of psychiatrists will be invaluable and should be utilized in such a way as to complement those of the general practitioner.

Summary

A questionnaire survey of the 488 doctors listed as general practitioners in Saskatchewan is reported. A 56 per cent response was obtained.

The background characteristics of this group together with the content of practice, treatment results, patterns of referral and some attitudes towards psychiatrists and allied professions are presented.

The general practitioners as a group stated that they treated large numbers of emotionally disturbed patients. Definite psychiatric disorders averaged 10 per cent of their practice; an additional 40 per cent showed emotional disturbances of varying severity. The number of such patients treated in medical wards by the doctors was actually greater than the number of their referrals to in-patient psychiatric units. Moderate or considerable interest in psychiatry was expressed by 80 per cent of the group; 74 per cent wanted to treat some of the patients they presently referred to psychiatrists. Over half of the doctors felt that all or most psychiatric patients could be treated in general hospitals. Most (60 per cent) felt that patients are still commonly anxious or resistive about seeing a psychiatrist.

It is felt that the evidence from this study and others supports the view that there is a large body of emotional disorder which never comes to the attention of psychiatrists. It is recommended that further studies be made of this population, particularly with a view to finding out how the skills of general practitioners and psychiatrists may be employed in a mutually beneficial way.

REFERENCES

1. Badgley, R. F., Smith, C. M., and McKerracher, D. G., Study of Mental Illness: The Public, Appendix 2 of this study.
2. Clute, K. F., *The General Practitioner.* University of Toronto Press, Toronto 1963.
3. Eysenck, H. J., "The Effects of Psychotherapy", *J. Cons. Psychol.*, 1952, **16**, 319.
4. Eysenck, H. J., "The Effects of Psychotherapy" in *Handbook of Abnormal Psychology,* Basic Books, N.Y. 1961.
5. Kessel, W. I. N., "Psychiatric Morbidity in a London General Practice", *Brit. J. Prev. Soc. Med.*, 1960, **14**, 16.
6. Kessel, N., and Shepherd, M., "Neurosis in Hospital and General Practice", *J. Ment. Sc.*, 1962, **108**, 159.
7. Nunnally, J., *Popular Conceptions of Mental Health,* Holt Rinehart and Winston Inc., 1961.
8. Pasamanick, B., "A Survey of Mental Disease in an Urban Population. IV. An Approach to Total Prevalence Rates", *Arch. Gen. Psychiat.* **5:** 151-155, 1961.
9. Pasamanick, B., Roberts, D. W., Lemkau, P. N., and Krueger, D. E., "A Survey of Mental Disease in an Urban Population. I. Prevalence by Age, Sex and Severity of Impairment", *Amer. J. Pub. Health,* **47:** 923-929, 1957.
10. Peterson, O. L., and Andrews, L. P., "An Analytical Study of N. Carolina General Practice", *J. Med. Ed.*, **31**, No. 12, Part II.
11. Primrose, E. J. R., *Psychological Illness: A Community Study.* C. C. Thomas, Springfield, Ill., and Ryerson Press, Toronto 1962.

APPENDIX 2

STUDY OF MENTAL ILLNESS: THE PUBLIC[1]

by

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Since the turn of the century concepts about mental illness have changed dramatically from a few well recognized ideas about treatment to a bewildering array of conflicting theories. Amid this plethora of psychiatric concepts and therapeutic techniques, one theme which has gained wide acceptance concerns the importance of considering the social characteristics of patients, the milieu from which they have come and the social setting to which they will be discharged. Undoubtedly, many factors partially account for this trend and there is a growing body of literature which substantiates this approach.

The results of many studies conducted by psychiatrists and social scientists suggest that the following propositions are valid about the relationship between mental illness and cultural and social variables.

1. Social and cultural variables are related to the etiology of various types of mental illness. (1-3)
2. The incidence and prevalence of mental illness, both reported and unreported, vary by the social and cultural backgrounds of patients. (4-8)
3. The social characteristics of the mental patient and the psychiatrist impinge upon the therapeutic process resulting in different patterns of "effective" treatment. (9-10)
4. The rates of discharge of patients from and re-admission to psychiatric treatment vary by social and cultural characteristics of the patients. (11-12)
5. The social structure of the mental hospital affects the outcome of psychiatric therapy of mental patients. (13-17)
6. The success or failure of specific mental health programmes varies with the types of information and attitudes held by a particular public. (18)

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[1] This study was carried out in 1962 under the direction of Dr. D. G. McKerracher for the Royal Commission on Health Services.

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This synopsis of findings is relevant since at the present time many proposals are being made about the organization of mental health services in the future. Among these are the open mental hospital, open mental wards in general hospitals, extensive treatment of mental illness by general practitioners and the erection of small regional mental hospitals. Since the effectiveness of these programs may partly depend upon acceptance by the public and their evaluation of such programs, it is pertinent to find out what laymen think of existing and proposed mental health facilities and what are their attitudes and knowledge about mental illness.

These considerations prompted the study which is reported upon here. Specifically, this study focuses upon the following questions.

1. What types of individuals are sought out for the discussion and treatment of mental health problems?
2. What types of facilities are preferred by the public for the treatment of mental illness?
3. What is the level of knowledge and the attitudes of individuals toward the mentally ill?
4. What is the degree of tolerance of individuals toward former mental hospital patients?

Setting and Methods

The present survey was carried out as part of a much larger study which dealt with the organization, both present and future, of mental health facilities and treatment programmes in Canada by Dr. D. G. McKerracher for the Royal Commission on Health Services. The scope of this study was limited by time, personnel and money which were available. Consequently, instead of focusing upon a broad representative sample of the general population, the results cited here refer only to a small atypical group who were willing to participate in the survey.

With the co-operation of the representatives of the Saskatchewan Wheat Pool, 220 members of this organization completed a questionnaire dealing with mental health and the mentally ill. Under no circumstances can it be construed that this group of respondents is representative of the general population. Although the information which is presented has many implications for the organization of mental health services, the explicit findings pertain only to this middle-aged (76 per cent), predominantly Protestant (79 per cent) group of male (95 per cent) Saskatchewan farmers (78 per cent).

The questionnaire which was used contained 26 items and was pre-tested on a small group of farmers attending a Wheat Pool meeting in a small community. In order to obtain comparability with other surveys, many of the items on the questionnaire were taken from surveys conducted by Crawford and the Cummings. (19-20) In Crawford's study a comparison is made with the findings of two other studies conducted in the United States and the results of the Cummings' survey were obtained in two communities in Saskatchewan in 1951. The information in the present study was transferred to I.B.M. cards and a significance level of .05 was used in all statistical tests.

Findings

(a) *Sources of Discussion and Treatment of Mental Health Problems*

The respondents were asked two questions about to whom they would turn if they needed either to talk about an emotional problem or to receive treatment for mental illness. Appended to each question was a list of eight types who might be referred to for help. These groups were ranked in order of importance by the respondents. Individuals deemed most important for the discussion or treatment of a mental health problem were scored one, while those deemed to be inappropriate for assistance were scored eight.

In Table I the only replies cited are those concerning individuals or groups who were thought to be "most important" in the treatment or discussion of mental health problems.

TABLE I

INDIVIDUALS SELECTED AS MOST IMPORTANT FOR DISCUSSION AND TREATMENT OF EMOTIONAL PROBLEMS OR MENTAL ILLNESS: BY PER CENT

Individuals Selected	Discussion of Problems	Treatment of Problems
Clergyman	35	12
Family doctor	26	33
Psychiatrist	20	47
Close friend	17	6
Nurse	0.5	0.5
Policeman	0.5	0
Chiropractor	0	0
Lawyer	0	0.5

$x^2 = 64.53$ p at .05 significant, calculated on actual frequencies rather than percentages on first four items.

For the individuals in the study it is apparent that some groups (nurses, policemen, chiropractors, lawyers) are seldom, if ever, referred to when an emotional problem arises. In contrast, other types of individuals may be sought out fairly frequently. Over a third of the individuals said they would discuss an emotional problem with a clergyman. Others selected as "most important" when an individual wanted to talk about a problem were the family doctor (26 per cent), the psychiatrist (20 per cent) and a close friend (17 per cent).

The groups sought out for the treatment of mental illness differ significantly from the groups with whom problems might be discussed. Almost half of the respondents (47 per cent) reported that the psychiatrist was the most important specialist to be consulted for the treatment of mental illness. In descending order of priority were cited the family doctor (33 per cent), the clergyman (12 per cent) and close friends (6 per cent). The replies to the two questions which were asked did not vary by an individual's age or level of education.

(b) *Location of Treatment*

At the present time in Canada many mental hospitals and mental health clinics are located a considerable distance from a large proportion of the

population. Many suggestions have been made that in the future small regional mental hospitals should be constructed and some of the wards of existing general hospitals should be used more extensively than at the present for the treatment of mentally ill patients. In the present study the respondents were asked where they would like to be treated if they were to become mentally ill. Each respondent ranked in order of preference a given alternative of a mental hospital, a mental ward in a general hospital, an ordinary ward of a general hospital or at home.

The first choice preferences of the respondents are summarized in Table II. Almost half of the respondents (48 per cent) indicated they would prefer to be treated in a mental hospital and over a quarter (28 per cent) selected the mental ward of a general hospital. The other alternatives of being treated in an ordinary ward of a general hospital and "at home" were the first choice of 10 per cent and 14 per cent respectively of the respondents.

TABLE II

LOCATION OF PREFERRED PLACE OF TREATMENT OF MENTAL ILLNESS BY RESPONDENT'S LEVEL OF EDUCATION: BY PER CENT

Level of Education	Place of Treatment				Total
	Mental Hospital	Mental Ward General Hospital	Ordinary Ward General Hospital	At Home	
—8 years	49	34	9	8	100
9—12 years	44	30	10	16	100
Post high school	41	12	12	35	100
Not reported	74	13	13	0	100
Average	48	28	10	14	100

$x^2 = 32.24$ p at .05 significant, calculated omitting replies citing Ordinary Ward, General Hospital.

Preference for place of treatment varied significantly by an individual's level of education. Less educated respondents more frequently chose a mental hospital or a mental ward of a general hospital, whereas more better educated respondents selected the ordinary wards of a general hospital or their homes as the place for treatment. There was no variation in the replies by the age of the respondents.

(c) *Knowledge and Attitudes About the Mentally Ill*

Recently there have been numerous surveys which have focused upon the opinions, attitudes and types of knowledge which individuals in the community hold about the mentally ill and mental health facilities. (21) Although the respondents in the study are not representative of the majority of the population either of the Province or of the Dominion, nevertheless, it is relevant to compare their replies with those obtained by other researchers.

Comparability through time in selected questions used has been achieved in three studies. These surveys are the Woodward poll of Louisville in 1950,(22) the Jaco study of Austin, Texas, in 1955 (23) and the Crawford report of four

communities in Texas in 1958.(24) Selected results of these three studies which have been compiled by Crawford in a recent article are presented with the findings of the present study in Table III.

TABLE III

COMPARISON OF KNOWLEDGE AND ATTITUDES CONCERNING THE MENTALLY ILL IN FOUR SURVEYS

Questionnaire Items	Percentage Positive Replies in Surveys			
	Roper (1950)	Jaco (1955)	Crawford (1958)	Wheat Pool (1962)
	%	%	%	%
1. Local medical facilities are inadequate	73	79	85	81
2. They won't face their problems	67	56	56	51
3. Mental illness is inherited	19	21	10	10
4. Mental Hospitals treat patients badly	32	37	16	4
5. Experts can't agree on who should be in insane asylums	65	69	52	50
6. Psychiatrists can help when someone acts queerly	89	80	87	82
7. If family members became mentally ill, I would:				
tell friends	48	62	71	79
keep quiet	52	38	29	21

Despite the fact that these studies were conducted in different communities, there is a remarkable similarity in the positive responses to the seven questions which were asked. In each instance the replies of the Wheat Pool respondents approximate the proportion of the positive responses reported in the other surveys. These results obtained from the Wheat Pool respondents who are not representative of the Saskatchewan population may have occurred by chance. However, such a coincidence on all seven items seems unlikely. The similarity in the results obtained suggests that in various North American communities many individuals appear to share common attitudes and opinions about the mentally ill.

The results in these four studies may also indicate that attitudes toward mental illness are changing through time. Crawford, in comparing his findings with those of Woodward and Jaco, makes the following comment.

"If the 'liberalizing' trend was evident in the 1955 data, it was evident to a higher degree in our data derived in 1958-59. The first of these 'liberal' attitudes on the part of our respondents suggests that the respondents believe (1) that local medical facilities are inadequate for handling cases of mental illness and (2) that

patients are not mistreated in mental hospitals. About the same proportion of respondents in our sample also indicated that it is worth while to get a psychiatrist's help when 'someone begins to act queerly.' On the surface, these expressions suggest that the idea of treating disturbed persons in mental hospitals, away from home and the community, by reputable psychiatrists is now generally accepted as part of our 'civil attitudes.' And, apparently, more of our respondents than in the two earlier samples, might communicate to friends the knowledge that a member of the family is mentally ill.

"The last two items dealt with 'reasons' why mental illness might appear: it is inherited—a thought rejected by the majority of the respondents; and mentally ill people just don't want to face their problems and troubles. There were no differences between the Texas samples concerning this latter statement."(25)

While it would be imprudent to place too much validity on the findings of the present study, nevertheless, they do appear to corroborate and extend the trends observed by Crawford. If these "liberalizing" trends are occurring, then there may be reason to believe that new programs for treatment of the mentally ill will be well received by the public.

(d) *Tolerance Toward Former Mental Patients*

Since 1950 there have been several studies which have focused upon the degree of tolerance which the public has for former mental hospital patients. Both Star in her national survey of the American population in 1950 and the Cummings in their study of two small communities in Saskatchewan in 1951 depicted the response pattern to the mentally ill as one of "denial, isolation and rejection."(26-27) Subsequently, studies by Jaco in 1955,(28) Crawford in 1958,(29) and Lemkau in Baltimore in 1960(30) have suggested that the American public is becoming more knowledgeable about the problems of the mentally ill and are showing greater tolerance toward former mental patients.

In order to gauge the degree of tolerance by the respondents in this study toward former mental patients, some of the questions used by the Cummings in their survey in this Province in 1951 were used. (31) The results of these two studies are presented in Table IV. The results of the two studies are roughly comparable when the percentage of positive replies to the five questions are compared. No clear-cut trend, however, has emerged, and for the two groups studied it appears that there has not been a major shift through time in the level of tolerance toward the mentally ill. The following observation by the Cummings appropriately summarizes the information in Table IV for both studies.

"The average person in this community is willing to live in the same neighbourhood with former mental hospital patients, but he stops short of 'rooming with a former mental hospital patient' and denies willingness for any closer association."(32)

In the Cummings' study responses to the five questions were related to an individual's age and educational background. Younger and better educated persons were prepared to tolerate more contact with former mental patients than were the older and less educated individuals. The findings in this study and in Lemkau's Baltimore survey did not confirm these trends cited by the Cummings.(33) Several factors may account for these differences in the three studies. In both the present study and Lemkau's survey different and perhaps atypical groups were studied and in both cases the questions were analyzed singly, not on a scale which was the method used in the Cummings' study.

TABLE IV
TOLERANCE TOWARD FORMER MENTAL PATIENTS BY RESPONDENTS IN CUMMINGS' STUDY AND WHEAT POOL SURVEY

Questionnaire Items[1]	Percentage of Positive Responses	
	Cummings	Wheat Pool
	%	%
1. We should strongly discourage our children from marrying anyone who has been mentally ill	26.1	41.4
2. I can imagine myself falling in love with a person who had been mentally ill	31.8	25.9
3. I would be willing to room with a former mental hospital patient	45.1	58.6
4. If I owned an empty lot beside my house I would be willing to sell it to a former mental hospital patient[2]	70.5	65.5
5. I would be willing to sponsor a person who had been mentally ill for membership in my favorite club or society	76.5	67.3

[1]Items taken from Care Social Distance Scale by E. Cumming and J. Cumming, *op. cit.*, Chapter 5 and Appendix 1. The results presented are an average of those obtained in Blackfoot and Deerville.
[2]In the survey of Wheat Pool members, this question, since it was addressed to farmers, was modified to "If I owned property beside my house I would be willing to sell it to a former mental hospital patient."

Discussion

The findings presented in this report have dealt with the opinions of 220 Wheat Pool respondents concerning who they would seek out for discussion and treatment of mental illness, where they would like to be treated if they were mentally ill and what they thought about the mentally ill. It is reiterated that the specific findings pertain only to the group studied although the data contain implications for the organization of mental health services and programs elsewhere.

Several authors have conceptually outlined the sequence which individuals follow when they are seeking medical assistance.(34-35) Individuals first tend to turn to those whom they know and trust such as clergymen, close friends and the family doctor. Querido has termed this stage of referral "the community's semi-permeable membrane", while Friedson has labelled this pattern "the lay referral system." From this stage individuals may proceed to seek medical care from physicians or other organized health services.

The findings in this study would tend to confirm this sequence of events concerning those who are sought out for the discussion of emotional problems and those from whom treatment of such problems might be requested. In the future, if small regional hospitals become a vogue and if closer liaison is to be sought between the community and mental health services, then the lay referral system may have to be considered as an integral phase of the therapeutic process. Lay individuals such as clergymen and close friends can act as vital and even indispensable sources of information and can provide informal counselling and

treatment both *before* an individual enters treatment and *after* a patient is discharged from treatment. In fact, the results of one study suggest that the social milieu to which a patient is discharged is directly related to whether a patient is maintained in a community or is readmitted to a mental hospital.(36) If this is the case, then, it seems mandatory that in the future there should be more planned involvement and greater co-ordination than currently exists between organized mental health services in conjunction with the work of local general practitioners and with the informal webs of human relations in the community.

What should be the role of the psychiatrist in the treatment of the mentally ill and how is this specialist accepted by the public? The data collected in this study and the results cited from other surveys suggest that the psychiatrist is widely recognized as the specialist who handles emotional problems and treats the mentally ill. But the psychiatrist is not the only physician sought out when mental illness occurs. Many of the respondents in this survey also said they would visit their family doctors. The study of general practitioners which was conducted jointly with the present study found that the average physician in a year admitted and treated twice as many patients with psychiatric problems as he referred to psychiatric in-patient units.(37) Considering the current shortage of psychiatrists and the fact that general practitioners are already handling many patients with mental health problems, it would seem appropriate that the work of these physicians should be closely co-ordinated with the programs carried out by psychiatrists.

Since the general practitioner has the confidence of many respondents for the handling of mental illness, then the psychiatrist in the future may be relegated to the role of the super-specialist who will treat only the difficult or unusual case. If this were to occur, the special skills of the psychiatrists who are in short supply might be more effectively distributed and utilized than at the present time.

Over three-quarters (76 per cent) of the respondents in the survey selected either a mental hospital or the mental ward of a general hospital as the preferred place for the treatment of mental illness. This finding is not unexpected since few (4 per cent) respondents felt mental hospitals treated their patients badly. However, it is probable that the definition of the type of mental illness which is to be treated in such centers differs from the concept of mental illness which may be handled by general practitioners. The former implies the stigma and the lable of "a mental patient"; the latter connotes fewer moral sanctions by the public. If acceptance of former mental patients by the public is related to where they are treated and by whom they are treated, then, as Lemkau has suggested, the onus of changing the structure of mental health services rests with the physicians.

> "It does seem reasonable that if the public identifies the mentally ill person as 'sick' the key to further attitude change is logically in the hands of those to whom society assigns the responsibility for the care of the ill—its physicians and medical institutions." (38)

The acceptance and tolerance of the mentally ill and of former mental patients may well have increased during the past few years. When the findings of this study were compared to other surveys, this trend seemed to be depicted by the data. However, the amount of social distance which individuals place between themselves and such patients stops short of complete personal acceptance. Only when there is widespread acceptance of mental illness as an

"ordinary" disease, of former mental patients as "cured" individuals and of mental hospitals as effective and desirable centers for psychiatric therapy, it is likely that the unknown mass of individuals in the community with psychiatric symptoms will be willing to seek psychiatric therapy. The pattern which appears to be emerging has been aptly described in another context by the Tocqueville as the difference between "street equals" and "home equals."(39) Former mental patients are gaining considerable acceptance as "street equals" but few appear to be accepted into the warm family setting as "home equals." If it is deemed desirable that this gap be bridged, then not only will extensive and effective programs of mental health education have to be carried out, but also as Lemkau has suggested, there must be an effective liaison between the psychiatrist, the general practitioner, and the community, and also a reorganization of mental health services so that the stigma of mental illness may be reduced. Only when former mental patients have achieved the status of "home equals" can the therapeutic process be deemed complete and effective.

REFERENCES

1. Myers, J. K., and Roberts, B. H.: *Family and Class Dynamics in Mental Illness,* New York: John Wiley and Sons, Inc., 1959.
2. Sullivan, H. S.: *The Interpersonal Theory of Psychiatry,* New York: W. W. Norton and Company, Inc., 1953.
3. Sullivan, H. S.: *Clinical Studies in Psychiatry,* New York: W. W. Norton and Company, Inc., 1956.
4. Faris, R. E. L., and Dunham, H. W.: *Mental Disorders in Urban Areas,* Chicago: University of Chicago Press, 1939.
5. Clausen, J. A.: "The Sociology of Mental Illness," in *Sociology Today* (editors, Merton, R. K., Broom, L. and Cottrell, L. S.), New York: Basic Books Inc., 1959, pp. 485-508.
6. Eaton, J. W., and Weil, R. J.: *Culture and Mental Disorders,* Glencoe: The Free Press, 1955.
7. Hollingshead, A. B., and Redlich, F. C.: *Social Class and Mental Illness,* New York: John Wiley and Sons, Inc., 1958.
8. Srole, L., Langner, T. S., Michael, S. T., Opler, M. K., and Rennie, T.A.C.: *Mental Health in the Metropolis,* Volume I, New York: McGraw-Hill Book Co., Inc. 1962.
9. Robinson, H. A., Redlich, F. C., and Myers, J. K.: "Social Structure and Psychiatric Treatment." *American Journal of Orthopsychiatry,* 24: 307-316, 1954.
10. Srole, L.: *et al., op. cit.,* pp. 247-249.
11. Freeman, H. E., and Simmons, O. G.: "Social Class and Posthospital Performance Levels," *American Sociological Review,* 24: 345-351, 1959.
12. Simmons, O. G., and Freeman, H. E.: "Familial Expectations and Posthospital Performance of Mental Patients," *Human Relations,* 12: 233-242, 1959.
13. Greenblatt, M., *et al.: From Custodial to Therapeutic Patient Care in Mental Hospitals,* New York: Russell Sage Foundation, 1955.
14. Henry, J.: "The Formal Social Structure of a Psychiatric Hospital," *Psychiatry,* 17: 139-151, 1954.
15. Jones, M.: *The Therapeutic Community,* New York: Basic Books, Inc., 1954.
16. Milbank Memorial Fund, *Decentralization of Psychiatric Services and Continuity of Care,* Proceedings of the 38th Annual Conference of the Milbank Memorial Fund, September 1961. New York: Milbank Memorial Fund, 1962.

17. Stanton, A., and Schwartz, M.: *The Mental Hospital,* New York: Basic Books, Inc., 1954.

18. Cumming, E., and Cumming J.: *Closed Ranks: An Experiment in Mental Health Education,* Cambridge: Harvard University Press, 1957.

19. *Ibid.*

20. Crawford, F. H., Rollins, G. W., and Sutherland, R. L.: "Variations in the Evaluation of the Mentally Ill," *Journal of Health and Human Behavior,* 1: 211-219, 1960.

21. Nunnally, J. C., *Popular Conceptions of Mental Health: Their Development and Change,* New York: Holt, Rinehart and Winston, Inc., 1961.

22. Woodward, J. L.: "Changing Ideas on Mental Illness and Its Treatment," *American Sociological Review,* 16: 443-454, 1951.

23. Jaco, E. G.: "Attitudes Toward, and Incidence of, Mental Disorders: A Research Note," *Southwestern Social Science Quarterly,* 38: 27-38, 1957.

24. Crawford: *op. cit.*

25. *Ibid.,* p. 215.

26. Star, S. A., cited in Lemkau, P.V., and Crocetti, G. M.: "An Urban Population's Opinion and Knowledge About Mental Illness," *American Journal of Psychiatry,* 118: 692-700, 1962.

27. Cumming, E., and Cumming, J.: *op. cit.*

28. Jaco, E. G.: *op. cit.*

29. Crawford, F. H., Rollins, G. W., and Sutherland, R. L.: *op. cit.*

30. Lemkau, P. V., and Crocetti, G. M.: *op. cit.*

31. Cumming, E., and Cumming, J., *op. cit.,* pp. 53-57 and 166-181.

32. *Ibid.,* p. 108.

33. Lemkau, P. V., and Crocetti, G. M.: *op. cit.*

34. Friedson, E.: *Patients' Views of Medical Practice,* New York: Russell Sage Foundation, 1961, pp. 133-151.

35. Querido, A.: "Early Diagnosis and Treatment Service," in *The Elements of a Community Mental Health Programme,* New York: Milbank Memorial Fund, 1956, pp. 158-181.

36. Simmons, O. G., and Freeman, H. E., *op. cit.*

37. These data are fully described in a paper by the present authors.

38. Lemkau, P. V., and Crocetti, G. M., *op cit.,* p. 698.

39. de Tocqueville, A.: *Democracy in America,* Volume I, New York: Vintage Books, 1954, p. 186.